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ABSTRACT

This document begins by presenting highlights of a seminar held in June of 1993 to describe innovative training programs that focus on interprofessional and family-centered forms of service delivery in the public sector and to discuss some of the issues, barriers, and challenges. Following these highlights is a background briefing report on training and technical assistance to support family-centered, integrated services reform. In the first sections of this briefing report, current trends, selected activities, and issues and questions in four major areas are discussed. The four areas include professional university-based training; inservice, on-the-job training; training for new careers; and technical assistance. Each section draws upon and briefly describes the related activities of a number of current initiatives that promise to have a sustained impact. Identifying information about the organizations sponsoring these initiatives is listed in the back of the report. Nine ambitious inservice training efforts, statewide in scope, are described; these nine training efforts are an integral part of ongoing reform efforts and several of them are linked with federal program reforms. Some recent trends in federal training programs are reviewed and suggestions are made for a number of ways in which the federal government could play a constructive leadership role in enhancing these new directions in training the human services workforce. The report ends with a list of 54 organizational resources and approximately 70 key references. (NB)

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Training and Technical Assistance to Support Family-Centered, Integrated Services Reform

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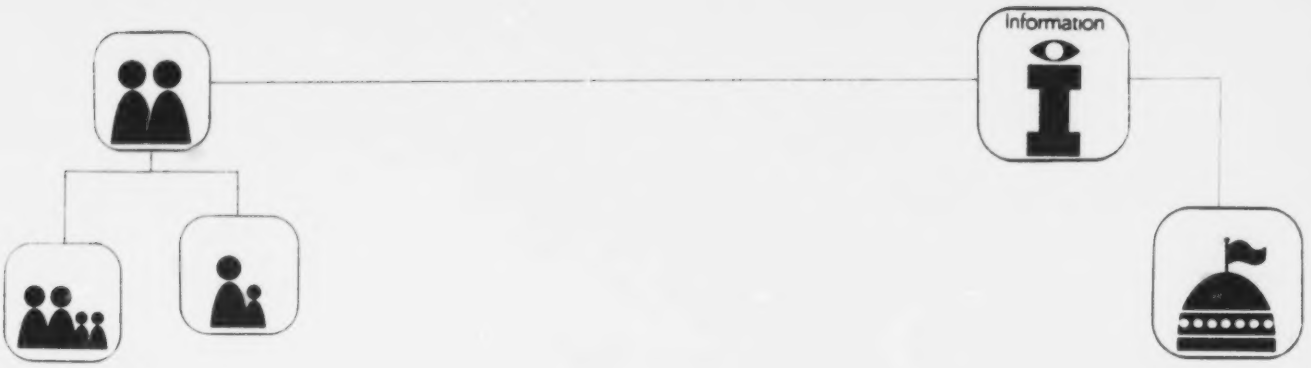

Training and Technical Assistance to Support Family-Centered, Integrated Services Reform

June 18, 1993, Hart Senate Office Building, Rm. 902

Panelists: **Sidney L. Gardner,** director, Center for Collaboration for Children, California State University
Karen Kelley-Ariwoola, senior training and program development specialist, Family Resource Coalition
Marion Lindblad-Goldberg, director, Family Therapy Training Center, Philadelphia Child Guidance Center
Patrick McCarthy, senior program officer, Center for Assessment and Policy Development, Bala Cynwyd, PA

Moderator: **Theodora Ooms**, director, Family Impact Seminar

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Training and Technical Assistance to Support Family-Centered, Integrated Services Reform

By

Elena Cohen

and

Theodora Ooms

This policy seminar is one in a series of monthly seminars for policy staff titled, *Family Centered Social Policy: The Emerging Agenda*, conducted by the **Family Impact Seminar**, American Association for Marriage and Family Therapy Research and Education Foundation, 1100 Seventeenth Street, N.W., Suite 901, Washington, D.C. 20036, 202/467-5114.

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TRAINING AND TECHNICAL ASSISTANCE TO SUPPORT FAMILY CENTERED, INTEGRATED SERVICES REFORM

Highlights of the seminar meeting held on June 18, 1993, in the Hart Senate Office Building, Room 902. (A supplement to the Background Briefing Report.)

Theodora Ooms, moderator, opened FIS's fourth seminar in its series on integrated services by indicating that there are a growing number of policymakers at state and local levels that understand that investment in staff training and technical assistance is essential to achieve the goals of any kind of policy reform. The purpose of the seminar was to describe innovative training programs that focus on interprofessional and family-centered forms of service delivery in the public sector and to discuss some of the issues, barriers, and challenges.

The first panelist was **Sidney L. Gardner,** director of the Center for Collaboration for Children, California State University at Fullerton. Gardner has a broad experience in the federal government and in the nonprofit sector and is now heavily involved with California's Healthy Start school-linked initiative. He is currently writing a book on the ethics of services integration.

Gardner compared some of the services integration initiatives of the 1970s to the current reform movement. Quoting Lee Schorr's work, he argued that we know a great deal more now, but two critical factors are still lacking: the funding streams that provide the incentives for people working with children and families to pull the pieces together and the people who know how to do it. Even though this seminar's goals were to discuss the "people" side of services integration, Gardner warned the audience to keep in mind the other critical aspect, funding streams.

The California State University system is trying to create a new type of professional who understands today's system, can work and think in family-centered, community-based ways, and acts as a change agent to create a less categorical system that is driven by outcomes. To reach these goals, the Center holds collaborative seminars four times a semester for undergraduates from five different departments (nursing, education, criminal justice, social work, and nursing) to come together and discuss different cases. These cases are selected because they demonstrate the need for multiple agencies and professional services.

In addition, the Center emphasizes field and internship placements for their students in agencies or programs that are implementing family-centered and integrated programs. They increasingly try to send students from different disciplines to the same agency for placement and hold periodic seminars on campus to discuss their field placement experience. These strategies allow professors, who are at times removed from the frontline, to become more cognizant of the need to work across agencies and disciplinary lines. The field placement experiences of students are then integrated into the regular curriculum of the different disciplines.

Gardner noted that representatives from 14 universities from around the country who are designing programs for interprofessional education convened at a conference last summer in Seattle, Washington. About 30 people will be meeting again in November 1993 to talk about what public and private institutions of higher learning are doing in this area (see page 4).

Barriers. Gardner enumerated several barriers to the implementation of collaborative preservice and inservice training. These barriers included the academic norms which make it extremely difficult to change the content of courses in universities; having an *additive* in contrast to a *reallocation* mentality---adding other units, courses, money, or pilot projects that sit by themselves, separate from the system; the credentialling processes and the fact that when professionals think that the goal of interprofessional training is to train people as generalists (who may displace established professions), training stops being discussed as a technical issue and becomes a political debate.

Because of these academic and political barriers, several public and private organizations outside the universities (i.e., the National Center for Service Integration, the American Association For Marriage and Family Therapy, and the Georgia Academy for Children and Families) are beginning to take the lead and providing training and technical assistance for state and local programs implementing service integration initiatives.

Federal role. Gardner added some comments about how the federal government could help. He said that it is important for Washington to try to design categorical programs in ways that they can be easily "hooked" into other categorical programs. For example, the upcoming reauthorization of Chapter I (Elementary and Secondary Education) is a great opportunity to think about how it could support school-linked services. Chapter I can provide the kinds of glue funding provisions that would make it easier to put the pieces together at the local level. The relationship between foster care and the Job Training and Partnership Act (JTPA) is an additional example of this type of "hook." It was once possible for a foster child to be automatically eligible to participate in JTPA activities. This eligibility meant that, along with other JTPA eligibility criteria in the welfare system, a person in the foster care system was presumed to need help in his or her way to independent living.

The federal government also has the responsibility of convening people that are designing or implementing training and technical assistance programs. The federal government has had an important role in providing funds for people to get together, talk to each other, and listen to what the others have to say.

To conclude, Gardner reiterated the critical importance of training. In his view, assigning a single professional, trained exclusively as a teacher, social worker, or counselor, to work with a family that needs help from more than one profession, agency, or program is equivalent to *malpractice*, since it provides a service in a way that is known to fail to meet the needs of the family.

Ooms introduced the second panelist, **Karen Kelley-Ariwoola,** senior training and program development specialist for the Family Resource Coalition (FRC). Kelley-Ariwoola works as a trainer and consultant to several family support initiatives. She was previously a program manager for the Ounce of Prevention Fund in Illinois. Kelley-Ariwoola described FRC's efforts to assist states in implementing the Family Support Act by training frontline workers in family-focused practice.

Case Management Training Curriculum. According to Kelley-Ariwoola there is a great mismatch between the complexity of the tasks that JOBS caseworkers are being asked to do

and the training that they usually receive. Training provided across states for JOBS caseworkers has ranged from a few hours of training on implementing the legislation and new policies and procedures to several days of training on case management. Very few states have conducted extensive training before implementing the new legislation and few are engaged in ongoing training.

In Connecticut, Florida, and Illinois, the Family Resource Coalition held focus groups and discussions with different levels of staff and with client families to determine what kind of training is appropriate for JOBS caseworkers to help families become self-sufficient. The six-day training curriculum (usually spread over a three-month period) that was ultimately developed is based on this information, family support literature, publications from the Foundation for Child Development and Project Match (a welfare-to-work program in Chicago), and the experiences of other community-based, family support programs. The curriculum is based on a framework that has five basic components: (a) a focus on a mutually respectful relationship between caseworkers and families; (b) a family-centered approach in which the individual is defined in the context of their family and the needs of the whole family are assessed; (c) the transition to work is defined as a process of human and family development over time; (d) the unique experiences and strengths of different cultural and racial groups are respected and supported; and (e) both both formal and informal networks of resources and support to the family are identified and supported.

Kelley-Ariwoola described some of the issues and barriers confronted when pilot testing the curriculum in Connecticut, Florida, and Illinois. One of the greatest barriers faced was the disagreement about definition of caseworkers' and supervisors' roles and, therefore, the skills and knowledge that they needed to acquire. For example, many supervisors do not see themselves as a "mentor" to practitioners; instead, they see the job as maintaining the system by making sure that everybody is following the correct procedures. Thus, she suggests that it is critical to clearly identify roles, competencies, and skills.

Another barrier discussed by Kelley-Ariwoola was the system of rewards and incentives. Most states' JOBS programs are evaluated on job placement rates. Frontline workers are not rewarded for the quality of their relationships, for the services they obtain for the other members of the family, or on the other issues being emphasized in the training.

Kelley-Ariwoola argued that in the state systems in which they were working, people had different ideas about the need for ongoing training in view of the current fiscal constraints. The training for JOBS caseworkers was possible because the FRC obtained private funding. However, most states have little money available for staff development purposes. In addition, many states do not have appropriate staff to do training or cannot afford to have their own staff do the training.

She concluded her remarks by emphasizing the important connection between training and systemic change and the need to involve key policymakers and administrative staff responsible for making the changes necessary to implement the training.

The third panelist was **Marion Lindblad-Goldberg,** director of the Family Therapy Training Center of the Philadelphia Child Guidance Center (PCGC), which has a contract with the state of Pennsylvania to conduct a statewide, home-based initiative. PCGC has been conducting family systems training in the public center for over 20 years (see page 21).

Pennsylvania home-based mental health initiative. The goal of this statewide initiative is to prevent the placement of children and adolescents who are considered at-risk. Lindblad-Goldberg indicated that one of the important features of this program is that the

philosophy of the initiative, as well as the service delivery, training, and evaluation model is multi-systemic and family-centered. Representatives from the five children's services agencies (mental health, juvenile justice, drug and alcohol, child welfare, and education), the Child and Adolescent Service System Program (CASSP) representative, and a parent representative serve on an interagency advisory committee to each county's home-based program. (The families served are referred by all these systems.) (See page 42 for more information on this initiative.)

Training of staff. The training of home-based clinicians follows the technical assistance provided to the project directors, agency directors, county administrators, CASSP representatives, and regional mental health administrators. The competency-based training curriculum for home-based clinicians consists of 53 days which are spread over a three-year period. The specific goals of the training are to help staff acquire the skills and knowledge necessary to deliver preventive services to families in their homes. The informational competencies included in the curriculum include, among others, knowledge, theory, and principles about clinical individual and family problems, child/family development, family functioning, assessment, intervention, and working across systems. At the end of the training the staff can enroll in a competency certification process with the possibility of receiving a certificate as a Systemic Home-Based Therapist. Training is also provided for supervisors.

Lindblad-Goldberg indicated that an important result of this training is that Medicaid has agreed to reimburse staff with a B.A. at the same rate as staff with a M.A., as long as these staff members are in training and complete the certification process.

Evaluation. The statewide evaluation of this program has measured changes in the functioning of children and families, as well as post-treatment placement experiences. Evaluation of the training has been limited to comparing staff retention rates for two service initiatives: a case management initiative where no training was provided versus a home-based initiative which included training. There was a 200 percent turnover rate for staff in the case management program and no turnover of the staff receiving the training. However, future evaluation plans will be measuring the effects of home-based training on client outcomes, specifically identifying worker characteristics, skills, and interventions that are associated with successful outcomes for families and children.

City of Baltimore training initiative. As part of the Target Cities Program grant received by Baltimore to improve its drug treatment services, the city awarded the Philadelphia Child Guidance Center's Family Therapy Training Center a two-year contract to provide family therapy training to all the city's publicly funded and some private substance abuse agencies. The training was targeted to 500 individuals, including administrators, supervisors, line staff, and nonclinical support staff. The training design included a period of intensive training to approximately 100 staff and to 8 potential local trainers. Each individual received 33 days of training, plus phone consultation as needed.

Lindblad-Goldberg indicated that after approximately two years of training several results are already evident. For example, the amount of family therapy has increased by 400 percent, staff morale is up, confidentiality releases have been changed, and intake procedures have been modified to include family members and significant others in the assessment and treatment process.

The final panelist was **Patrick McCarthy,** senior program officer, Center for Assessment and Policy Development, a private nonprofit research and consulting firm serving as the liaison to states participating in the Pew Charitable Trust's Children's Initiative. Previously, McCarthy worked for Delaware's Department of Services for Children, Youth, and Their

Families, where he initiated an ambitious, multi-level project to reorient the agency toward a family-focused approach to service delivery.

McCarthy indicates that organizations usually provide training either to ensure a certain level of proficiency in a task (i.e., filling out a form) or to focus on particular skills (i.e., interviewing). However, he argued that organizations can also use training as a way to give their workers a different view of the world, a different conceptual framework, or a different lens to think about the work they do. Yet another function of training is as a lever to transform the culture of an organization. In this type of training, staff are encouraged to re-examine their own organizational culture and the mission of the organization to help it become a *learning organization.*

To provide examples of the use of training and technical assistance as elements of larger systemic change efforts, McCarthy described his experiences in Delaware and the Children's Initiative.

The **Delaware Family Focus** initiative, which grew out of the family preservation program, was initially seen as an opportunity to train all frontline workers in family systems theory and skills. Relatively soon, however, it became obvious that key stakeholders like the middle managers and the directors of the agency were not "on board" and, therefore, they were subjecting workers to dissonance by asking them to comply with policy procedures different from what they were being asked to do in their training. In addition to providing training to the entire agency staff (including frontline workers and support staff such as accountants, secretaries, janitors, etc.). They decided to contract with Salvador Minuchin and Jorge Colapinto from the Family Studies Institute to provide one day of training to all of the senior policy makers and mangers, including the cabinet secretary and division directors. Administrators were helped to realize the difference of thinking holistically rather than categorically, as they observed Minuchin and Colapinto work with a family involved with multiple agencies with in the department. The training program has now evolved into much more of an organizational development strategy under the leadership of John VanDeusen, Jay Lappin, and Jamshed Morenas. Delaware continues to provide training, but the focus has changed: management has become the *target* for change and frontline workers have become the *agents* of change, rather than what is often the other way around.

The **Pew Charitable Trust's Children's Initiative** is an ambitious effort to provide preventive, family-focused services with the goal of improving outcomes for children and families. States are being asked to reconfigure their entire continuum of services towards more preventive and early intervention services, rather than purely remedial services. The training and technical piece of this initiative is rather ambitious as well. (See page 18 for a description of the Pew Initiative.)

McCarthy highlighted the following lessons derived from his experiences providing training and technical assistance in these two projects. (i) Training needs to be seen as a strategy to change behavior of all the staff; therefore the first step is to ensure that the key stakeholders are involved in the training. (ii) Administrators and managers should be trained in the same ways that clinicians are trained; that is, they should be trained to respond to the needs of families rather than trying to squeeze the families into categorical programs. (iii) The best approaches to training are those that provide plenty of opportunities for apprenticeship and mentoring, using people within the organization that are culture bearers. (iv) Consumers of services need to be used as trainers.

McCarthy closed by making a few comments about the federal role in training. In his opinion, the federal government should encourage experimentation and support cross-disciplinary

collaboration in preservice and inservice training. This support should go beyond training in collaboration to encourage training for integration.

Points made during the discussion

- A person from the Administration for Children and Families asked McCarthy if the training conducted in Delaware included a piece on helping managers understand the cultures and perspectives of the other agencies so that they could collaborate more effectively.

  McCarthy indicated that this was not part of the original planning. However, they were lucky enough that another effort of cross-agency collaboration began about two years after the family focus program, and both programs were able to provide family-centered training across departments.

- A participant from the Department of Education asked if there is any empirical evidence about the effectiveness of training as a tool for organizational transformation.

  McCarthy indicated there was none that he knew about, largely because research and evaluation are highly vulnerable activities that get cut off when there are budget limitations.

  Gardner responded that in order to conduct research there needs to be a comparative assessment of what is meant by *systems reform*, and what this looks like at the state and local levels. Gardner indicated that the line between formative evaluation, mid-course correction, and technical assistance is very thin and that currently there is no tool by which administrators can assess whether there has been an organizational transformation towards more integrated service delivery. He thinks that there should be a scale (divided by different content areas like financing, intake process, etc.) to assess state or local government progress as they move from their current way of operating to a family-focused, integrated system.

- A member of the audience, from the Chapter I Office in the Department of Education, asked if there was any outcome or other type of evaluation conducted to assess the effectiveness of the FRC's JOBS case management training.

  Kelley-Ariwoola indicated that the grant was too small to fund any type of evaluation beyond the pre- and post-tests given at each training session, participant evaluations, and observations of the actual training sessions. She indicated that for this kind of project, the evaluation must include longitudinal assessment of the changes that occur well after the training.

  Kelley-Ariwoola responded that workers generally reported that they enjoyed the training they received and that it was very different from anything they had received before. Elements of the training that workers evaluated negatively included the frustration of not being able to implement some of what they learned because of large caseloads and lack of support from some supervisors or others in the system.

- A member of the audience asked about the use of interactive technology in training.

  Gardner indicated that some of the school-linked programs in California have taken current technology as far as it could go. For example, they have stitched together different intake forms into a single intake process in a family assessment. But the technology can take programs only so far. Then they hit the policy that initially presents itself as a confidentiality issue. In most of the cases (as documented in two recent studies in Hobbs,

1991, and Joining Forces, *et al.*, 1992) the basic issue is one of accountability. If a worker has five systems up on the screen and they are all supposedly able to serve that family, the technology will not ensure that the services are delivered. It comes down to whether or not the staff who have the data go back and inquire if the services were provided to the family.

Gardner added that the data may be useful to push caseworkers in one system to collaborate with the caseworkers in other systems with whom their families interact. Finally, he noted that technology can also be useful to determine how much money is coming into specific communities. With these data, the policy and political questions address whether or not the money is being used as effectively as people in that community would like it to be.

Lindblad-Goldberg spoke about another type of technology, namely camcorders, one-way mirrors, and videotapes which are used extensively in the training provided by the PCGC's Family Therapy Training Center. Getting the state of Pennsylvania to embrace this type of training and investing in the equipment was a milestone for the training project. However, she argued that she would not like to train people with computers or teleconferencing because it runs against the primary goal of training which is for people to learn to connect with other people. The process of connection has to be modeled and enacted in the training situation and it cannot be done using computers. She also indicated that in the evaluation of the training program, students rated the networking and relationships with other students as one of the most important aspects of the training.

- A person from Fairfax County (Virginia) commented that when you talk about transforming a culture, you automatically assume that there is some dissonance between the training and the organizational context and that the training automatically challenges the system. He requested more information about what is an acceptable level of dissonance and what is meant by organizational context.

  McCarthy suggested that there are two ways of looking at the fit between the training and the organizational context. One is that there has to be a certain amount of dissonance between what the training is attempting to bring in and what is already there (if not, then what is the point of training). Secondly, assuming that a shared vision exists for what the nature of the change needs to be, the dissonance can be managed more effectively because the stakeholders are in a way *inviting the dissonance*. Unfortunately, the latter seldom happens. Most of the time training is brought in because it looks good on annual reports or other public relations pieces. What is not anticipated when training is brought into an organization is that frontline workers start pressuring for change. Hopefully these pressures move up if key stakeholders are attentive to it.

- A participant asked all the panelists whether they had included other nonprofits in their trainings and what they thought was the role of nonprofits and private agencies in training initiatives.

  McCarthy described the model of the Georgia Academy for Children and Youth Professionals which is a new nonprofit training center that has contracts to train both in the public and the private sectors (see description on page 20).

  Gardner suggested that funders can create incentives for the most entrepreneurial nonprofit organizations to take the lead in the training of new professionals. He described the example of the United Way. In a few areas, the United Way is putting some of their money in an outcome-driven category instead of funding all traditional projects. They identify a few projects and "walk them through" a two- or three-year transition. Because the two critical elements for an outcome-driven project are noncategorical funding streams

and a different type of professional, they are developing ways of dealing with these two issues.

Gardner pointed out that the discussion about outcomes is beginning to take place on a community-wide level (i.e., score cards, Kids Count). However, not enough is done at the micro level (basing payment on results). According to Gardner, unless some of the leading nonprofits provide different incentives for funding, there will continue to be dissonance between preaching for outcomes-based funding and the way programs are funded.

Ooms affirmed that it may be easier for agencies in the nonprofit sector to change their training efforts because they are under less bureaucratic rules, union pressures, and other barriers. However, there are some public sector initiatives beginning to provide bonuses to workers based on results.

Kelley-Ariwoola commented on the opportunities that exist within the JOBS program and other programs to train staff working in state systems together with staff from community-based and nonprofit agencies. Lindblad-Goldberg indicated that cross-agency training (both from public and private agencies) is one of the goals of the CASSP initiative in Pennsylvania.

- A participant from Zero to Three, the National Center for Clinical Infant Programs asked if there have been any plans to take the JOBS training to other states.

Kelley-Ariwoola responded that FRC's curriculum includes a set of core skills that are necessary not only for practitioners working in state welfare offices, but for all those providing family-centered services (see page 14). She believes it is the responsibility of the federal office to identify and make this information about training available to all states.

- A person from the Annie E. Casey Foundation indicated that everything that was talked about had implications for the federal government and asked if any of the panelists or of the members of the audience had ideas on suggestions for Congress or the executive branch on potential federal strategies and opportunities to facilitate the kind of training that was described.

Gardner reiterated his idea of using categorical training money as "glue" to either link several systems together or to train people in some of the generic cross-cutting skills that are required across systems, like data management or evaluation. He suggested that the federal government has to lower the walls between the different kinds of training because the children and families served in one system are usually the same ones being served in the other systems. In addition, Gardner suggested that the federal government set aside a small portion of funding for projects that are specifically cross-systems initiatives.

In California, Gardner said, there is some pending legislation for multidisciplinary education, which deliberately is not supposed to set out a new pot of money to fund anything new. Rather, it is to build an inventory of all staff development and inservice money already in the system and pool these dollars to fund interprofessional education.

In conclusion, he thought that the federal government could take inventory, construct hooks at the edge of different categorical training programs, create incentives for cross-systems training, and convene staff from the different agencies because they all are working with the same children and families.

Lindblad-Goldberg suggested that the federal government do what was done in Pennsylvania, that is, bring together different agencies for training within the framework of family-centered philosophy. Although family-centered means something different in education, child welfare, and child mental health, obstacles of "turf" are surpassed when all participants share common principles. Currently, most programs serving children have a mission that shares this philosophy.

- A staff person from the Children's Bureau argued that to speak about the "federal government" may not be an accurate picture. There are many, many Senate and House committees, departments, and organizations. She reminded the audience that at one time the Children's Bureau had made an inventory of all the different agencies that dealt with children and families and how they were coordinating with each other. This indicated that it takes a great deal of energy to coordinate programs and that federal staff get tired or take other jobs and, therefore, coordination efforts never seem to be institutionalized.

  Ooms asked a representative from Assistant Secretary for Planning and Evaluation (ASPE) if his office has an interest in cross-agency training. He responded that it did not, training is seen to be the responsibility of each of the programs.

TRAINING AND TECHNICAL ASSISTANCE TO SUPPORT FAMILY-CENTERED, INTEGRATED SERVICES REFORM

Background Briefing Report

INTRODUCTION

There is widespread agreement that the current categorical child and family service system is largely ineffective, wasteful, and does not respond to the needs of today's families. As a result, a growing number of reform initiatives at both state and local levels are striving to find more effective ways to deliver services to children and their families. Although these initiatives vary a great deal in scope and program content, they share a commitment to making services more easily accessible, comprehensive, flexible, coordinated, community-based, and family-centered.

The knowledge, skills, and capacities of the managers, supervisors, and frontline workers in human service agencies are critical components of all program implementation. The success of any reform initiative depends heavily on the extent to which human service personnel understand and accept the new desired directions, and learn how to implement them.

Most of the numerous reform initiatives underway have focused initially on the governance, administrative, and financial changes critical to the implementation of reform and focused little on training. (By contrast, a few reforms, notably Idaho and Delaware, grew out of an ambitious agency-wide training initiative.) Yet the success of all these changes is heavily dependent upon whether they are accompanied by new approaches at the frontline, that is, at the intersection where services are delivered to families. These new approaches require managers and frontline staff to learn to think much more broadly and comprehensively, and interact in many new ways with each other, their clients, and with other professionals and service providers.

Unfortunately, as Lee Schorr argues, "frontline staff often lack the skills needed to build respectful, trusting relationships, to work collaboratively with families and with systems and disciplines other than their own, and to be comfortable exercising discretion in dealing with a complex interplay of problems. Program managers, in turn, often lack the skills to keep a program evolving in response to changing needs, and to recruit and supervise professionals to work in an unbureaucratic, outcome-oriented organization" (Schorr, 1993: p. 100).

State and local reform initiatives are beginning to pay a lot more attention to the importance of providing training to frontline workers and supervisors and technical assistance to managers. To respond to this need, new training models, curricula, and job categories are being developed with the help of a number of organizations in the private sector. In addition, a few universities, looking ahead at the needs of the future labor force, are reexamining the design of current, highly specialized and isolated professional training programs and developing cross-disciplinary, team approaches to preparing human service professionals for working with families in these new ways. This cross-disciplinary, team approach is also being used as a strategy for inservice training. Finally, in each of the traditional disciplines there are some trends towards incorporating more of a focus on a family-centered approach in their curricula, and new family-focused specialties and disciplines have been established in the health care professions.

Traditionally, federal policymakers have paid little attention to issues of training, especially at the federal level. Training monies are minimal, and are usually the first to be cut. Even when new legislation mandates significant reforms, training is added as an afterthought, if at all. For example, several recent federal reforms (P.L. 99-457, The Education of the Handicapped Act Amendment of 1986; the Family Support Act in 1988; and the Comprehensive Child Development Act of 1988 [P.L. 100-297]) require many changes in service delivery which have profound implications for personnel preparation and inservice training. By mandating comprehensive, coordinated services and specific intervention components such as family assessment, interdisciplinary planning, and case management, the legislation is indirectly mandating quantitative and qualitative changes in professional preparation programs. Yet not enough resources are provided to implement these changes. But here too there are some signs of change.

The emerging new interest in training and technical assistance is assuming a degree of urgency as bold reform initiatives anxiously struggle to live up to the promises of reform. Yet very little information is available in written form about the new training and technical assistance activities. This seminar and briefing report are designed to fill this gap. This report is not the result of a systematic or comprehensive survey, but is a preliminary attempt to identify and describe the different types of training and technical assistance being offered, the challenges and barriers these efforts have to confront, and the issues and questions that they raise for policymakers and others. Most demonstration programs and community-based service integration initiatives include a staff training component, but these are usually short lived. We have chosen to focus here only on those initiatives that have some promise of a more sustained impact on human resource development.

This is the fourth report in the series, *Coordination, Collaboration, Integration: Strategies for Serving Families More Effectively*. The first two reports provided an overview of the wide scope of the services integration movement which is taking place simultaneously in every major program sector, and presented some of the service integration initiatives at local and state levels (see Ooms and Owen, 1991 [a] and [b]). The third report in this series discussed the role of case management in accomplishing the goals of providing coordinated, efficient, and effective services for families within the present system. A fifth seminar is planned that will address issues of data and evaluation needs.

Organization and focus of the report

In the first sections of this report we discuss current trends, selected activities, and issues and questions in four major areas: Part I, Professional University-Based Training; Part II, Inservice, On-the-Job Training; Part III, Training for New Careers; and Part IV, Technical Assistance. In each section, we draw upon and briefly describe the related activities of a number of current initiatives that promise to have a sustained impact. Identifying information about the organizations sponsoring these initiatives is listed in the back of the report on page 54.

In Part V we select and describe nine ambitious inservice training efforts, statewide in scope, that are an integral part of ongoing reform efforts. Several of these are linked with federal program reforms. Part VI includes reviews of some recent trends in federal training programs and suggestions of a number of ways in which the federal government could play a constructive leadership role in enhancing these new directions in training the human services workforce. The report ends with a list of organizational resources and key references.

Definitional notes

(i) The term **services integration (SI)**, following the usage of the past three reports in this series, is used as a broad umbrella term to cover a wide range of initiatives involving collaboration

and coordination between existing categorical programs and sometimes substantial financial and administrative integration of two or more programs. Services integration was historically seen as a means to achieve more cost-efficient and user-friendly systems of service delivery to individuals. It is currently seen as an integral component of strategies to improve outcomes for children and their families.

(ii) Family-centered programs. This term is used rather loosely in current reform discussions. Some family-centered reform initiatives are primarily interested in improving outcomes for individual children and adolescents. In these initiatives, family-centeredness, usually meaning involving the parent(s) or other family members, is seen as a more effective way to helping the child. Other family-centered initiatives are focused on providing services for members of at least two-generations in the family, and increasingly for all the members of the family. An explicit service goal in these programs is to strengthen the functioning of the family unit as a whole. In general, it is these initiatives that we try to highlight in this report.

(iii) Human services personnel training is the process of transferring accumulated knowledge to ensure that individuals attain the basic competencies necessary to be able to deliver health, education, and social services. Training can be engaged in as part of professional preparation (preservice) or when a person is already on staff (inservice). Agencies may conduct the training in house or through contracts with outside organizations or individuals. The training process includes conceptual knowledge (which is usually done through course work) and practice skills, learning to implement these concepts in direct interaction with the clients/consumers of services during the supervised field practice (internships). Attainment of the competencies is usually determined by an evaluation which determines that the skills have been mastered. In addition, most state licensing authorities and professional associations require some form of continuing education to ensure that professionals are informed of the latest technology and developments in the field.

PART I. HUMAN SERVICE PROFESSIONAL PREPARATION

(Sources: Gardner, 1992; Human Services Policy Center, 1991 and 1992; Thompson, 1990; University of Washington/California State University, 1992)

Preservice or professional preparation refers to the process of education that occurs over several years, usually in an accredited institution of higher learning. Although differences exist among the various professional categories that work in human services programs (social workers, nurses, mental health professionals, and teachers), most careers follow a similar sequence: (a) initial preparation which consists mainly of course work; (b) internship or field placement; (c) a period after graduation in which the new professional is supervised by a more experienced colleague; and (d) certification into the membership of the professional association.

When new theories evolve, new knowledge or technology is developed, or with the changing needs of clients or legislative mandates, the content and sometimes the methods of this professional preparation must be redesigned. For example, to be effective, comprehensive services for children and families must be provided by teams of collaborating professionals in a way which meets a multiplicity of needs and which recognizes the different aspects of functioning in both the home and the community. To do this, staff in the programs need to have a sufficient knowledge of each others' disciplines to allow them to recognize problems, refer when appropriate, and work jointly with families and other providers toward an appropriate solution. Similarly, when the focus of services shifts from the individual to include the individual's family and social context, program staff need to acquire new knowledge about family needs and functions and new skills in how to interview, assess, and collaborate with different members of a family.

Currently, most institutions of higher learning segregate different disciplines in separate departments. When they do include some components of other disciplines in the curricula, the program does not include skills in collaboration or on how to work with families as partners. Therefore, the current reform movement toward a family-centered and integrated service delivery requires a substantial change in the preservice preparation of many different human service professionals, social workers, educators, health care professionals, and others.

New Initiatives in Interprofessional Education

Interprofessional education is designed to facilitate communication, cooperation, and coordination between members of two or more disciplines. Each discipline needs to learn enough about the other's basic concepts, technical language (professional jargon), and skills to know how to communicate and plan to work together effectively. It is essentially a "building bridges" exercise which may may range from simple communication of ideas, to the mutual integration of organizing concepts, methodologies, and procedures in a larger field. In an interprofessional team, members of the team may substitute for each other, building on and complementing each others' special expertise and perspectives. The nurse may take a social history alone on occasions or in conjunction with the social worker. The physician may suggest that the social worker explore specific issues or the entire team may ask the nurse or the nutritionist to explore a feeding problem. If the problem is complicated, they may even do it together. This is the type of education that is being encouraged by most of the university programs described in this section.

A number of colleges and universities are designing programs of interprofessional education and research by training students in their chosen field while exposing them to a variety of interprofessional activities. Although these programs use a variety of strategies, most of them are reorienting course requirements to broader themes of collaboration, field placements/supervision, and inservice training. Each of these programs has encountered a number of institutional barriers and sometimes met with strong resistance from colleagues and the university administration, but are creatively finding ways of overcoming them. The following are several examples of these efforts. (Contacts and addresses are available on page 54.)

Center for Collaboration For Children, California State University, Fullerton

This Center, funded in 1991, is a California State University (CSU) system-wide initiative. The Center's mission is to improve the California State University system's capacity to meet the needs of children and youth in the 21st century. CSU is the primary source of education and training for thousands of professionals who serve children in California, such as nurses, teachers, social workers, and counselors.

Besides CSU-Fullerton, CSU-Los Angeles, CSU-Fresno, and San Francisco State have been selected as Center participants. All the sites have received funding from the Chancellor's Discretionary Fund grant given to the Center. The Center received additional funding from the Annie E. Casey Foundation.

The Center encourages different categories of multidisciplinary practice.

- Collaboration/linkages *within a single discipline,* such as early intervention programs based in special education.

- Collaboration/linkages *within a single target group,* such as Head Start's health, social services, nutrition, and parental involvement components, as a supplement to early childhood education for preschoolers.

- Collaboration/linkages that *cut across both disciplines and target groups,* such as state-level strategic planning for a family policy.

The Center appoints Fellows to work on changing some of the ways human service professionals are being educated. The Fellows, a multidisciplinary team of faculty on participating CSU campuses, engage in activities such as reviewing curricula and course content; conducting ongoing policy research and data collection; exploring the implications for university preparation of professionals who will be expected to work in collaborative, school-based or community-based settings; exploring the theoretical models that undergird collaboration; and communicating the results of their scholarly activities to a variety of audiences both within the university and the community.

Other activities of the Center include a collaboration with the University of California at Berkeley to provide support to a task force working on legislation (AB 2765) which would require the Superintendent of Public Instruction, the Secretary of Health and Welfare, and the Secretary of Child Development and Education to form "a task force on professional development for integrated children and family services programs or teams." The bill passed the Ways and Means Committee but did not win floor approval. It will be reintroduced as AB 1763 in the summer of 1993, as AB 1763.

The Center for Collaboration for Children at California State University-Fullerton, and the University of Washington's Human Services Policy Center, sponsored a **Conference on Interprofessional Education** at the University of Washington in the summer of 1992 with support from the Stuart and Annie E. Casey Foundations. It was attended by faculty from different professional schools in fourteen institutions of postsecondary education, mostly universities (and other representatives of foundations, associations, and state governments). The goal of this conference was to allow institutions of higher learning that are involved in developing multidisciplinary, interprofessional training programs to exchange information and examine their individual programs within the framework of the movement toward family-focused and integrated service delivery.

The following were the six components of multidisciplinary education that the group discussed:

- Curriculum review and revision;
- Changes in field placement, internships, and supervision of field-based education;
- Inservice training and extended education;
- Technical assistance for collaborative state and local efforts;
- Evaluation of collaborative state and local efforts; and
- Policy research across disciplines.

A second conference is planned for November 1993.

Commission on Interprofessional Education and Practice, Ohio State University

This Commission was created in 1973 to provide institutional structure to collaborative dialogue that had been occurring between academicians and practitioners about the provision of preservice courses and continuing education experiences to prepare professionals for interprofessional practice. Faculty members from the colleges and schools of education, law, medicine, nursing, public administration, and social work designed and now offer credit courses which introduce

students in each of the schools to interprofessional theory and practice and offer continuing education experiences that help practitioners engage in interprofessional dialogue and practice.

The University's receptivity to experimenting with various programs of implementation have supported the Commission's work. The Provost has included support for the Commission in his budget and issued a challenge to the cooperating institutions and associations to create line items in their budgets for the Commission. In addition, teaching in Commission courses was incorporated into the regular teaching load of the participating faculty members. Additional funding was secured from the Columbus Foundation and two large grants from the W.K. Kellogg Foundation. External funding, however, is never sought as a substitute for core funding.

In order to expand its scope, the Commission created a statewide assembly which now includes a variety of professional schools and associations from every region in Ohio.

Interprofessional Education Project. Research and Training Center on Family Support and Children's Mental Health

The overall goal of the Research and Training Center on Family Support and Children's Mental Health is to improve services for families whose children have serious mental, emotional, or behavioral disorders. The Center is funded by the National Institute on Disability and Rehabilitation Research (NIDRR), U.S. Department of Education, and the National Institute of Mental Health, U.S. Department of Health and Human Services.

The Center's *Interprofessional Education Project* is designed to increase the extent to which state-of-the-art principles of family-centered, culturally appropriate, community-based services are reflected in the training of service providers, planners, and administrators who work with families whose children have emotional disorders.

Currently, the project is preparing a concept paper outlining principles, practices, and standards for interdisciplinary education in children's mental health. It is also conducting a study to assess how well current training programs prepare professionals to provide services to children and youth with emotional disorders and their families, identifying training needs in the field, assessing the extent to which current training programs exemplify principles of interdisciplinary education, and identifying professional training programs that exemplify state-of-the-art principles of interprofessional education. The findings and recommendations will be disseminated to professional training programs, practitioners, administrators, and family organizations throughout the country.

The project has developed the following frameworks: (a) Foundation for Integrated Practice in Children's Mental Health and (b) Model of Education for Collaborative Practice in Children's Mental Health.

Training for Interprofessional Collaboration (TIC), Human Services Policy Center, University of Washington

This is a four-year project to develop and pilot a new model of inservice and preservice training within the University to identify and instill skills necessary to train teachers and other educators, social workers, health professionals, administrators, and policy analysts to design and deliver integrated, client-responsive human services to children and families. Among the foundations funding this project are the Stuart Foundation and the DeWitt Wallace-Reader's Digest Fund.

The Deans of the Schools of Education, Public Affairs, Public Health and Community Medicine, Social Work, and Nursing are committed to building a collaborative approach into the core curricula of their schools. This commitment is evidenced by the financial and substantive support provided to the faculty involved in the project. The University Provost is also committed to this project.

Project activities provide:

- Experience, guidance, and role models of collaborative practice to students of participating schools;
- Inservice training to practitioners at diverse sites to assure that services are effectively integrated and the practitioners have the capacity to serve as mentors to university students;
- Development of both inservice and preservice curricula;
- Analysis of professional roles and competencies required for effective interprofessional service delivery;
- A broad-based project advisory board to provide linkages between the practitioners, professional societies, state funding and certification agencies, ethnic communities, and businesses; and
- Evaluation of both the collaborative processes and the impact on professional attitudes, competencies, and career choices.

We summarize here several recent developments in the training of human service professionals which are a reflection of, and in turn are contributing to, the emergence of family-centered and collaborative service systems.

Trends in Teacher Education

There is scant evidence that many teacher education programs are incorporating multidisciplinary content into their preservice course curriculum or training teachers to work with other professionals. A survey of over 500 teacher educators in five southwestern states revealed that extremely little is included in the curriculum about families and how to work with parents, although 80% of school principals and teacher educators agreed that such content should be required (Chavkin and Williams, 1988). However, two promising new projects suggest that a new trend may be emerging that will help prepare education personnel to participate more effectively in the new service reforms and work collaboratively with other professionals.

American Association of Colleges for Teacher Education (AACTE) Project

AACTE, with funding from the DeWitt Wallace-Reader's Digest Fund, awarded four, three-year demonstration grants to university teacher education programs to implement projects that are designed to foster new collaborative applications in human service preparation programs. These projects were selected among the 40 programs that responded to the RFP developed by AACTE last summer.

The AACTE project will serve as a forum for several models from which duplication guidelines will be developed and distributed. At the project's midpoint, a nationwide teleconference will be conducted to broaden the discussion and share the results.

The four projects funded are:

- **Jackson State University (Mississippi).** Project TEACH (Teacher Advancement Through Collaboration with Human Services) will focus on research in minority communities as it develops and implements a collaborative strategy for teacher education.

- **University of Louisville (Kentucky).** The Center for the Collaborative Advancement of the Teaching Profession, the School of Medicine's Division of Community Health, Preventative Medicine and Biometrics, and the Kent School of Social Work are teaming up with three local public schools and two of the new state-mandated Youth Service Centers to develop a comprehensive service training model based on "wellness" priorities for children and families.

- **University of New Mexico (Albuquerque),** in partnership with the newly established and integrated New Mexico Department for Children, Youth and Families, will utilize Albuquerque Public Schools Human Service Collaborative to implement a field-based training program for interns from teacher education, community health education, and family studies.

- **University of Washington (Seattle).** The schools of education, social work, nursing, public affairs, and public health and community medicine have designed a Training for Interprofessional Collaboration project (see page 6).

Family-Centered, Collaborative Trends in Social Work Education
(Source: Bardill and Saunders, 1988)

Social work is an integrative profession, drawing upon a wide range of disciplinary knowledge which is involved in many domains of practice ranging from social policy and administration, social and community action, and clinical practice in public and private settings. Currently, social work education occurs at the Bachelor's, Master's, and doctoral levels.

Historically, the family unit was a major focus of social worker's concern. In the late 19th and early 20th centuries, the early pioneers, such as Mary Richmond, cautioned against only interviewing individuals and prescribed interventions with the whole family. Many of these social workers were based in settlement houses and operated from a systems perspective, appreciating the influence of environmental factors on personal and social behavior. They made home visits and worked with marital, parenting, and health problems as well as helping with the harsh economic realities of unemployment, housing, and income.

In the 1920s and 1930s, as it came heavily under the influence of psychoanalytic theory and practice, the social work profession shifted its emphasis to focus more on clinical work with individuals. It also substantially abandoned its commitment of outreach to the families of the poor and disadvantaged. "Psychiatric social workers practiced on mental health teams and as a result, individuals, families, and treatment became fragmented with each professional on the team (psychiatrist, psychologist, and social worker) responsible for certain pieces of the patients, their families, and their treatments" (Bardill and Sanders, 1988: p. 320). In the postwar period, this model of clinical practice continued to permeate the social work profession and, increasingly, those entering social work schools did so in order to learn how to become private practice therapists.

However, a subgroup of the social work profession has maintained an interest in social action and social policy, and there is growing interest among social work students in taking courses in marriage and family therapy. However, the recently published formal accreditation standards for the profession, promulgated by the Accreditation Commission of the Council of Social Work Education Commission, give scant attention to families and do not mention family therapy as an area of specialization for social work.

In addition to these emerging trends towards more family-centered professional training curricula, two projects of national significance described below demonstrate that social work is once again broadening its focus and attempting to strengthening its commitment to the public sector and to working with other human service professionals.

Fordham University

Since 1986, the Departments of Social Work and Education at Fordham University have sponsored an innovative collaboration called the Stay-in-School Partnership program, which unites parents, public school teachers, and Fordham's graduate schools of education and social service in a common task: keeping at-risk New York City elementary students in school. The program has proven to be highly successful both at reducing absenteeism and increasing parents' involvement in their children's education.

The DeWitt Wallace-Reader's Digest Fund gave Fordham a planning grant to investigate similar collaborations at other universities and to propose a strategy for replication of their program. In its final report, Fordham noted that although the school dropout problem demands collaborative, interdisciplinary approaches with students and their families, most such collaborative projects at the university level have been small, externally funded projects that were not sustained once the funding ended. The strategy proposed was to establish a National Network of the Graduate Schools of Education and Social Work to support children and families in the public schools.

DeWitt Wallace has provided the funding to develop a network of ten universities known for their interest and leadership in education and social work collaboration. With the help of other members, the Network will establish regional centers to develop model teacher/social work programs and serve as training sites for universities throughout the fifty states.

The Network will:

- Establish a national clearinghouse and database to collect and disseminate information on intragraduate school collaboration.
- Encourage graduate schools of education and social work to engage in interdisciplinary activities and train teachers and social workers to provide comprehensive services for at-risk youngsters in public schools.
- Study and evaluate the best ways to deliver collaborative services, and develop curricula/instructional materials which recognize the contributions of both teachers and social workers.
- Establish ten regional centers to support and encourage university collaborations nationally.

Public Sector/Social Work Education Project, National Association of Social Workers (NASW)

(Note: This collaborative professional training project is included here because it has important implications for professionalizing and strengthening the labor force of public sector social welfare agencies. However, it does not include a specific focus on preparing personnel for comprehensive, integrated, or family-centered services.)

The Ford Foundation and the National Institute of Mental Health provided funding to the Council on Social Work Education (CSWE) for an initiative to improve the capacity of social work schools to educate students for careers in publicly supported human service agencies. This project, which grew out of an initial effort focused on personnel preparation in child welfare, is a collaborative effort between CSWE, NASW, the National Association of Deans and Directors, Baccalaureate Program Directors, the Child Welfare League of America, and the American Public Welfare Association.

These organizations have been working together to develop strategies to strengthen social work's commitment and ability to serve at-risk, vulnerable families through Bachelor's and Master's degree curriculum development, research, agency staff training, and participation in the design of service reforms. The organizations are examining issues such as course content, field placement, research, faculty-agency staff exchanges, service delivery systems design, and staff recruitment and retention.

This project has reviewed over 70 examples of collaborative efforts. Public agencies participating in these collaborations include child welfare, community mental health, substance abuse, inpatient psychiatric facilities, housing services, income maintenance/JOBS programs, hospitals, and public schools.

Family-Centered, Collaborative Trends in Training Health Care Professionals

There is a great deal of ferment in the field of medical education and within the last few years several foundation-funded efforts have been launched to broaden and improve medical education. In 1992, the report of the R.W. Johnson Foundation Commission on Medical Education recommended that in addition to their biological knowledge, physicians must have an understanding of the behavioral and social aspects of disease and must be trained to work in community settings. The Health Professions Commission, funded by Pew Charitable Trusts, made some similar recommendations. It emphasized the need for physicians to learn to work in multi-disciplinary teams and included as one of the core required competencies that physicians needed to learn to involve patients and their families in the decisionmaking process (Marston, 1992; O'Neill, 1992).

In addition to these emerging general trends, two new family-focused health care specialties, family medicine and family nursing, and one new discipline, marriage and family therapy, have been created within the last four decades, requiring new types of training programs. They arose in response to the growing frustration with the overspecialization and narrow focus of the dominant medical paradigm and the organization of the professions. Both biological and behavioral research pointed to the need for more holistic approaches to physical and mental health. Studies provided dramatic evidence of the importance influence of family factors on individuals' health status. The history of the emergence of each these new trends is complex and can only be very briefly summarized here.

• **Family Medicine.** In 1969, family practice was officially established as medicine's twentieth primary specialty. The national membership organization is the American Academy of Family

Physicians (AAFP). This new specialty emerged as a deliberate strategy for upgrading the knowledge and skills of general practitioners and attracting more generalists into the health care profession. The American Academy of Family Physicians defines family practice as "comprehensive medical care with particular emphasis on the family unit, in which the physician's continuing responsibility for health care is not limited by the patient's age or sex nor by a particular organ system or disease entity. Family practice is the specialty in breadth which builds upon a core knowledge derived from other disciplines---drawing most heavily on internal medicine, pediatrics, obstetrics, gynecology, gerontology, surgery, and psychiatry---and which establishes a cohesive unit, combining the behavioral sciences with the traditional biological and clinical sciences...The family physician serves as the patient's or family's advocate in all health-related matters, including the appropriate use of consultants and community resources." The three-year residency program also requires instruction in human behavior and community medicine and includes courses in family dynamics and the stages of stress in the family life cycle.

Currently, there are around 74,000 family practitioners, of whom more than half have graduated since 1969 from the over 400 approved family practice specialty programs. (The other members are general practitioners who took some additional continuing education credits.) Members of the Society for Teachers of Family Medicine, an independent but allied organization, are developing new models of collaborative health care practice, working especially closely with medical family therapists among others. A newly established journal, *Family Systems Medicine*, reports on the growing body of research and practice models emerging from the collaborations between family medicine, family therapy practice, and family systems theory.

• **Family Nursing.** Nurses have always been the members of the medical team who have the most frequent contact with families. Historically, nursing was usually practiced in the home. This tradition has been continued by public health nurses working with the very poor and rural families. However, when the bulk of nursing practice shifted from home to hospital, most nurses withdrew and had minimal contact with families.

In the last decade there has been a major shift back towards the family. Health care providers are increasingly recognizing the impact of illness on the family, the influence of family interaction on the course of illness and recovery, and the impact of the family's environment on their ability to cope with and manage the care and treatment of their ill member. "Nursing is once again inviting families to participate in both home care and hospital treatment...Family nursing has come to mean nursing care of the well and the sick, and health counseling for all members of the family" (Wright and Leahey, 1988).

This shift in practice emphasis is reflected in some shifts in nursing training curricula. Thus, at the undergraduate level, many nursing programs now teach family nursing within the community health or mental health part of the curriculum. This is increasingly true at the graduate level as well. Many practising nurses, especially those who graduated before 1970, are enrolling in continuing education courses in family nursing. In addition, a few programs at the graduate level are offering family therapy courses, and clinical supervision and family therapy in nursing is gradually evolving as a new specialty in the profession. An important new contribution to the health care professional training literature is the three-volume *Family Nursing Series*, which emphasizes assessment and intervention for specific health problems (Leahey and Wright, 1987, 1987 [a] and [b]).

• **Family Therapy.** Marriage and family therapy (MFT) emerged in the late fifties and early sixties as a new and distinct profession. The profession views individuals' needs and problems as strongly influenced by the primary contexts in which they live, most notably the family. Marriage and family therapy has been recognized by the Department of Education as the fifth core mental health discipline. MFT Master's, doctoral, and post-graduate degree programs are offered in 73 accredited, university-based training programs. Historically, MFT evolved from social work,

psychiatry, and marriage counselling, and many people continue to enter the field from a variety of professional backgrounds, including social work, psychiatry, psychology, nursing, pastoral counseling, and education. The diversity has enriched the field by bringing multidisciplinary perspectives to bear on the problems of individuals and families. And the fact that marriage and family therapy is grounded in family systems theories and methods has brought unity to the field. MFTs practice in many settings, both public and private, and fill a variety of roles.

The American Association for Marriage and Family Therapy's Commission on Accreditation for Marriage and Family Therapy Education is officially recognized as the sole accrediting authority for marriage and family therapy education. Clinical Membership in AAMFT, available only to those who meet the educational credentials, has grown very rapidly, from less than 300 members in 1960 to over 20,000 in 1993.

One of family therapy's most distinctive and admired features is its training and supervision methods and techniques. These include the use of one-way mirrors and telephones for live observation of family interviews and the use of videotaped sessions. In addition, trainees and experienced therapists have access to videotaped and live family sessions conducted by the leading experts in the field. Another distinctive feature is its highly structured and demanding credential programming for supervisors (see p. 16).

As more and more MFTs practice as consultants and collaborators in school, medical, child welfare, juvenile court, and other settings, some MFT training programs are developing training curricula and materials to train MFTs in approaches to collaboration with other professionals and service systems. In addition, free-standing family therapy institutes and the AAMFT annual conference provide many opportunities for learning about approaches in working in public agency settings and with special populations in need (i.e., AIDS, substance abuse, and domestic violence).

KEY ISSUES AND QUESTIONS ABOUT INNOVATIVE PRESERVICE EDUCATION

(Sources: Center for the Collaboration for Children, 1992; Center for the Collaboration for Children/University of Washington, 1993; Costello and Ogletree, 1993; Gallagher, *et al.,* 1989; Quaranta, *et al.,* 1992)

Balance between generalists and specialists. There is some concern that the trend towards interdisciplinary education and collaborative team practice may lead to an overemphasis on generalist knowledge to the detriment of specialist knowledge. However, advocates for interprofessional education do not seek to replace specialization with a purely generalist outlook on practice. Instead, they try to build better bridges among disciplines so practitioners schooled in these disciplines can reinforce and support each other in meeting the needs of children and families.

When individuals and families need multiple services, a collaborative team of specialists can balance these two needed components of professional education and practice. Typically one member of the team assumes the role of generalist and case manager or coordinator. Communication and joint planning and assessment can be facilitated by case conferences.

Family-centered practice. Another concern is that when training is highly family-focused staff may receive insufficient training to respond to the specific needs of individuals. For example, the curriculum may not sufficiently emphasize issues of individual development and functioning and, thus, the family-centered practitioner may not notice evidence of a child's learning disability or signs of the parent's depression or alcoholism. Again there needs to be a balance and the best

family-based training programs ensure that the trainees receive a firm foundation in child and adult development and functioning.

Minority professionals. Many public agencies are currently ill-equipped to serve the needs of an increasingly diverse population. Because professionals who work in public agencies often do not come from the same ethnic or class backgrounds as the families they serve, the cultural and language gaps can be enormous. These gaps seriously impair the ability of agencies and their employees to offer the best assistance to diverse families. Moreover, this issue is of even stronger salience for family-centered services since different ethnic groups have different family patterns, professionals must be drawn from a representative range of cultural backgrounds in order to develop and provide effective service. This concern has led to a renewed interest in the New Careers Movement (see p. 26).

Strategies to reach out to involve minorities in interprofessional training programs are especially important because disadvantaged minorities may be particularly risk-averse, and require extra incentives to participate in an approach which is not yet perceived as central to a professional career.

Academic barriers to collaborative training. Numerous institutional barriers exist within universities that make it very difficult to institute interprofessional, cross-disciplinary education. University promotion, tenure, and salary systems reward research in a specialty discipline. Multidisciplinary research, publication in interdisciplinary journals, and working in applied fields is generally discouraged and certainly seldom encouraged.

Government and private foundations can provide funding or other incentives to overcome these issues of professional turf and competitiveness. If the universities are not able to respond to these emerging professional training needs, it seems very likely that non-academic organizations outside the universities will come forth to do so, as indeed is already happening in the area of inservice training (see p. 17).

State barriers. The movement toward interprofessional training is inhibited by state certification standards for professionals. In addition to codifying standards of practice, certification standards often specify how many credits of what types of courses individuals must study to qualify. Unless such standards require courses that are built upon, or are compatible with, a collaborative, family-centered practice approach, then the limit on total course-hours students can take may inhibit the inclusion of appropriate material in professional curricula.

Professional accreditation standards. Training programs must also be responsive to the requirements of the national accrediting bodies in the various professions. Again, these requirements often greatly inhibit the incorporation of new forms of training. For example, when clinical hours only count towards the credential when the families are seen in a medical or office-based setting, and are disallowed when seen in the home or school or when the clinical contact is with another professional involved with the family.

As the movement for interprofessional and collaborative training moves forward, it will be important to find ways to convince the national professional associations and accrediting bodies that these developments are necessary and need to be encouraged and institutionalized.

PART II. INSERVICE/ON-THE-JOB TRAINING

(Sources: Bailey, *et al.*, 1989; Fenichel and Eggbeer, 1991; Gallagher, *et al.*, 1989; Hughes and Rycus, 1989; Wynn, *et al.*, 1992)

Inservice/on-the-job training is the process by which personnel working in human service programs are provided with a variety of experiences designed to learn practical skills, or to improve or change their professional practice through actual work with assigned families. It can be either an integral part of preservice (i.e., field work, internship) or post-professional training (i.e., once hired). The format and location of inservice training can vary a great deal, ranging from one-day institutes, semester-long courses, or regular weekly or monthly training sessions conducted over a period of years. Supervision and "oversight" by a more experienced practitioner is an important part of inservice training.

The curriculum of on-the-job training focuses on how to develop the interpersonal skills to deliver actual services to individuals and families in need. The methods can vary a good deal. They may include didactic, paper and pencil exercises, role playing, and discussions of case histories or case interviews. Family-centered training programs often use video tapes of interviews with families or live observation behind one-way mirrors.

Ongoing, inservice training for staff is essential for many reasons, including: (a) It is only through experiences in applying preservice knowledge in a "real world" that professional refine their skills; (b) After gaining professional credentials, continuing education is useful for learning more advanced skills and about new emerging technologies, and to meet newly emerging needs (such as AIDS) related to professional practice; (c) Inservice education is an essential mechanism to replace obsolete practices with those documented to be more effective; and (d) For many staff, continuing inservice education through clinical supervision is necessary to ensure adequate quality of service.

The format and components of inservice education vary in many ways according to both the purpose for, and manner in, which it is provided. Key components of inservice training are: (1) the curriculum; (2) supervision; and (3) conferences and workshops.

(1) Inservice Training Curricula

(Source: Hughes and Rycus, 1990)

Development of a written curriculum is often a key component of inservice training as it assures that it can be replicated and continually improved. The following are two examples of new curricula that have been developed to provide inservice training in family-centered or integrated approaches.

- **Family Support Training Manual for JOBS Workers**

  As part of the Training and Support Project for states implementing the Family Support Act, the Family Resource Coalition is completing the development of a comprehensive training manual for direct service personnel (see FRC, 1993). The curriculum is based on family support principles which promote an approach to service delivery that is preventive, community-based, culturally responsive, comprehensive, family strengthening, skill building, and empowering.

  FRC's initiative was designed to respond to the key provisions and mandates of the Family Support Act of 1988. In their work with JOBS programs in three pilot states (Connecticut, Florida, and Illinois), FRC staff observed that it is at the frontline worker level that the

philosophy and intent of the JOBS program is translated. Therefore, they targeted their efforts to increasing the capacities of staff at this level. The biggest barrier confronted was the philosophy and practices of the welfare system that focuses solely on individuals' deficits, and defines individuals not as part of a larger whole (family) whose sum is indeed greater than its parts, but whose parts are easily divided and separately served by the system.

Frontline JOBS workers were receptive to the concepts and techniques presented in the training. Of special interest were sessions on community resources, working with teen parents, and a welfare simulation activity that allowed workers to experience a "month on welfare" from a family's perspective. Among the barriers confronted in the training of frontline staff were the contradiction between the family support approach and the philosophy and practices of the welfare system, huge caseloads which prevented workers from delivering true family support services, and the absence of an effective system of training and supervision that could provide ongoing training and sustain the new practices introduced in the initial training.

The curriculum was piloted in three sites and is now being sold to states adopting a family support approach in their JOBS program.

- **Collaborative Leadership Development Program (CLDP)**

The Institute for Educational Leadership (IEL) has developed a curriculum that provides a series of learning experiences (including experiential exercises, readings, lectures, and other materials) to enable leaders in the education and human services systems to learn to collaborate.

The goals of this curriculum are: (a) To equip leaders with knowledge and skills to enable them to function in a more collaborative manner; (b) To enable leaders to engage in collaborative problem-solving processes designed to achieve systemic change; and (c) To assist leaders to develop a lasting culture of collaborative community problem solving by building a growing network of people with collaborative leadership skills.

Although the basic themes of collaboration are the same for staff at different levels, the nature of the leadership skills that individuals at each level need to develop will vary. IEL adapts the curriculum and learning experiences to fit the needs of policymakers and agency executives, mid-level professionals, and frontline workers.

(2) Systems of Supervision
(Source: Kadushin, 1976)

Supervision is a vitally important part of preservice and ongoing on-the-job training. Narrowly, supervision can be defined as the process of teaching professionals how to conduct their work, however, it frequently affects many other aspects of a worker's professional and personal development. Supervision usually includes reflecting and challenging participants both personally and intellectually in a safe context in which the trainee's style can emerge. Thus, it is a context for conceptualization, action, and personal growth.

- **Social Work Supervision**

Supervision has always been a primary method of preservice and inservice training of social workers and primarily takes place in individual conferences between trainee and supervisor. Social work students are presumed to require close and continuing supervision for a certain

number of years and the improvement of professional practice is assumed to rest on consistent and close clinical supervision. To become certified or licensed as a social worker, individuals must continue to be supervised for at least two years after graduating from an approved MSW program. Because social workers perform a wide spectrum of activities, once on staff of an agency the emphasis can shift between using supervision as an educational process to more of an administrative process. Sometimes it provides both functions.

We mention below two fields that are placing a strong emphasis on supervision as a tool to assure more integrated and family-centered service delivery.

- **Early Intervention**
(Source: Fenichel, 1993)

The National Center for Clinical Infant Programs (NCCIP) is giving increasing attention to the needs of the field of early intervention for well-qualified supervisors and mentors, trained in interdisciplinary approaches. As part of its project on *Learning Through Supervision and Mentorship,* NCCIP convened a multidisciplinary work group in 1991 to identify key issues related to supervision and mentorship in the training of practitioners who work with infants, toddlers, and their families and to suggest strategies for incorporating supervision and mentorship into training and practice institutions and systems.

NCCIP's Supervision and Mentorship project identified the following three essential elements of supervision: (a) *reflection,* which involves stepping back from the immediate intense experience of hands-on work; (b) *collaboration,* which involves shared power, clear mutual expectations, and open communication; and (c) *regularity,* which indicates that time must be allocated for the supervisory relationship and that this time must be protected.

Supervision provides opportunities for the individual participant to: (a) broaden knowledge; (b) reflect regularly, in a safe environment, on the full range of reactions to the experience of practice; (c) discuss individual goals and measure progress toward them; (d) develop and refine one's professional use of self and individual style through increased self-understanding; and (e) learn from a more experienced practitioner who describes why and how he/she works as he/she does---and discusses both successes and failures in the course of one's own professional development.

- **Family Therapy Supervision**
(Source: Liddle, *et al.,* 1992)

Supervision is a critical component in preservice and inservice training and employment of marriage and family therapists and the profession has developed a clear set of standards and expectations for supervisors, and the training of supervisors.

Family therapy's emphasis on observing and affecting the interactive process between couples, family members, and the therapist requires a method of supervision capable of directly accessing this process. Therapist recall, process notes, and even audiotapes---the primary methods of supervision used by social work and other disciplines---can not capture the richness and complexity of interactions in a family therapy session. Consequently, several means of direct observation have evolved, such as live observation behind a one-way mirror and videotaping interviews. When these are not possible due to the absence of the needed equipment, the supervisor may join in the trainees interview.

The American Association for Marriage and Family Therapy (AAMFT) grants an Approved Supervisor designation. This accreditation signifies completion of the marriage and family therapy education, experience, and supervision of supervision requirements established by AAMFT. The Approved Supervisor may hold one of a variety of theoretical orientations in marriage and family therapy and may practice supervision in many ways, but it has to be from a systemic orientation. It is a functional designation which applies to the clinical and ethical standards and is granted for a five-year term which can be renewed.

(3) Conferences and Training Institutes

Most major human service professional associations organize conferences and special training institutes for their members. These conferences provide the opportunity for staff to learn new knowledge both within and across their discipline, and upgrade clinical skills. Some of these may be approved for continuing education credits some states require for continued licensing. For example, the National Center for Clinical Infant Programs plans national and regional conferences, typically two and a half days in length, that focus on clinical issues of current importance to the field and also address pertinent research, administrative, and social policy concerns.

The AAMFT Annual Conference is also highly valued as a continuing education opportunity. In addition, many family therapy centers throughout the country offer courses, workshops, or ongoing training externships designed for beginning or advanced therapists to upgrade clinical skills and learn to work in new ways or with new types of problems and special populations.

INSERVICE TRAINING INITIATIVES

A growing number of organizations and free-standing institutes (see list of resources) are providing innovative on-the-job training and consultation to local service reform initiatives in several program areas. Others are developing training materials and guides that can be used by local trainers. In addition, unknown numbers of private consultants are involved in providing training directly or designing training programs. The following brief descriptions of selected family-centered and/or integrated services training efforts provide a flavor of this fast moving field. (Addresses and names of key contacts are listed on p. 54.)

Behavioral Sciences Institute (BSI) Homebuilders Program

Begun in Tacoma, Washington, in 1974, Homebuilders is a program of the Behavioral Sciences Institute. It is an intensive and time-limited (six weeks) family preservation service designed to keep families intact and to improve family functioning when there there is a child at risk of foster placement. Highly trained therapists work with only two families at a time, performing an array of activities ranging from helping with material necessities (e.g., food, clothing, and shelter), to teaching about emotions, behaviors, and interpersonal relationships. Each family receives a highly individualized and flexible treatment plan. The family and therapist work from that plan to achieve treatment goals. Homebuilders is the best known of a number of models of family preservation services and has been widely adopted in many states and in other countries (see Ooms and Binder, 1992).

The implementation of Homebuilders programs requires highly trained staff. BSI offers training, consultation, and assistance to public and private agencies initiating family preservation programs. The training includes training and consultation for administrators, supervisors, and frontline staff.

Center for Assessment and Policy Development (CAPD)

A few foundations are initiating large-scale efforts to reorient and reconfigure services for children toward an integrated, preventive, and family-focused delivery system. One of these initiatives is *The Children's Initiative*, funded by The Pew Charitable Trusts. This initiative, which is administered by CAPD, requires fundamental changes in the philosophy, structure, and practice of services systems to improve outcomes in child health, child development, school readiness, and family functioning.

The service strategy of *The Children's Initiative* has several required components: (a) development of a system of inclusion, i.e., a system of ensuring that all families with children are provided support, including a range of health, educational, and social services, through strategies such as outreach to pregnant women, universal contact with families of newborns, and universal contact at the point of school entry; (b) a network of neighborhood family centers to serve as the hub of the system of inclusion and as a major focus of activities and efforts to strengthen the local community; (c) development of a new form of frontline practice which is more flexible, comprehensive, family-focused, and supportive of family resources; and (d) a reconfiguration of the existing system of services from the current categorical, fragmented, remedial, and deficit-based approach to a community-designed, holistic, integrated system with a full continuum of preventive and early intervention services.

Examples of specific types of issues that must be addressed by the five states submitting proposals (Florida, Georgia, Kentucky, Minnesota, and Rhode Island) are:

- Recruitment and training criteria for family development specialists;
- Overall system training and retraining policies geared toward a more comprehensive, preventive, and family approach to service;
- Determination of worker empowering management and supervision; and
- Resolution of intergovernmental, interagency, and interdisciplinary disparities in job definition, compensation, performance evaluation, and lines of authority.

The Family Resource Coalition has established the general framework for the development of the training curricula that will be used by the three states that are finally selected for long-term funding. CAPD will pull together a team of trainers from around the country to provide the technical assistance to the selected states. (The implementation grants will be announced in March 1994.)

Center for Development of Human Services

This Center is a not-for-profit training and human resource development enterprise at Buffalo State College. Its mission is to assist community human service agencies to improve the quality of their services by providing professional training and program development for their staff. The Center has the following divisions: New York State Child Welfare Institute; New York State Regions I and II Independent Living Resource Center; Children with AIDS Training Program; New York State Medical Assistance Training Institute; Human Resource Management Institute; Human Services Management Information Systems; and Program Evaluation. In addition, the Center is reaching out to national markets with new versions of products that have been successful in the state.

Family Resource Coalition (FRC)

Responding to the growing need to develop a conceptual framework for training in the family support approach, FRC launched a **Best Practices in Family Support** initiative as a starting

point for future work in training/technical assistance, evaluation, policy development, and practitioner credentialing. The project is funded by the A.L. Mailman Foundation and the Annie E. Casey Foundation.

Many family support programs have been developing a base of experience with new approaches in their own communities, but few have attempted, or have the resources, to establish training protocols for application on a wider scale. Key to the success of these programs, regardless of their origin or the specific services they provide, is the training and development of staff members who come from a range of disciplines, i.e., social work, psychology, child development, health, community development, etc. Current interest in using family support techniques in a variety of human services programs has created a demand for clearer guidelines for staff training.

The three main goals of this initiative are to: (a) conduct a thorough review of current research, theory, and evaluation in the field; (b) consult with practitioners in the community-based, family resource field to document and legitimize their experience regarding best practices; and (c) develop a constituency of practitioners, trainers, academics, policymakers, funders, and parents to support the application of best practices standards. FRC is preparing a monograph, *Developing a Conceptual Framework for Training in Family Support.*

FRC is collaborating with three other organizations in a new project titled, **Improving Frontline Practice in Comprehensive Community Service Systems.** This project is the training and technical assistance component of the Improved Outcomes for Children Initiative, an ambitious effort to restructure 200 schools in conjunction with strengthened health and human services, all in the interest of improving children's educational outcomes. The broader work is being conducted by the National Alliance for Restructuring Education, coordinated by the National Center for Education and the Economy (NCEE). This project is funded by the Danforth Foundation.

The Family Resource Coalition is working on this aspect (training) of the larger technical assistance effort with NCEE, the Harvard Project for Effective Services, and the Center for the Study of Social Policy. All these organizations are combining their skills to provide to three selected sites technical assistance related to the wide range of practice, policy, finance, and service delivery changes that must be made across education and human services systems.

The goals of this effort are to:

- Develop and implement family-centered training for teachers, social service workers, health care workers, and other frontline personnel involved in improving educational outcomes for children. Training will be provided in a uniform fashion across agency and system boundaries.
- Develop and test ways in which schools and human service agencies can support staffs' new approach to families.
- Assist participating sites to develop an ongoing, family-centered staff development capacity so that this approach becomes a permanent part of their professional development.
- Disseminate the materials and experience gained through this effort to the field at large.

The results expected are a family-centered curriculum which can be used by many professions and adapted in many sites and ongoing training programs to demonstrate that the approach can be institutionalized as part of an ongoing staff development program.

The Georgia Academy for Children Youth Professionals

The Georgia Academy is a new initiative created by the Robert Woodruff Foundation and the state of Georgia as a public/private partnership to address the training and information needs of Georgia's public and private professionals who deliver services to children. The Academy has two missions:

(1) To serve as a multidisciplinary educational institution for professional and community leaders involved in the delivery of services to children and youth. At this moment they are implementing a statewide training system to be delivered regionally.

(2) To assist public and private child serving organizations to develop more effective ways to improve the lives of Georgia's children and families.

The Georgia Academy promotes family-centered practice, family preservation, community and organizational collaboration, service integration, public/private partnership, and outcome-oriented services. The Academy utilizes competency-based, interdisciplinary, and experiential training.

National Committee for the Prevention of Child Abuse, Healthy Families America Initiative

The National Committee for Prevention of Child Abuse (NCPCA), in partnership with the Ronald McDonald Children's Charities has launched a national initiative, *"Healthy Families America,"* to replicate across the country the Hawaii model of family-focused, home-visiting, child abuse prevention. NCPCA is working in conjunction with the Hawaii Family Stress Center, the NCPCA chapter network, the state Children's Trust Funds, state maternal and child health departments, and other interested state and national organizations. The initiative provides training materials, technical assistance site visits, and training to interested state personnel. (See page 39 for a description of the training.)

National Resource Center on Family Based Services (NRCFBS)

For over ten years, the NRCFBS has provided workshops to managers, supervisors, direct service workers, and paraprofessionals, training an average of 2,000 individuals per year. The Center has worked with child welfare, mental health, juvenile justice, community action, county extension, Head Start, and job training programs throughout the United States and abroad. Funded by the Department of Health and Human Services, the Center's primary objective is the development of high quality family support, family development, family preservation, and family-centered services across the country.

On-site training programs are individualized for each agency's needs and residency programs are periodically offered on campus at the University of Iowa. The training format includes lecture, discussion, demonstration, practice, and videotapes, with an emphasis on encouraging participants' own creative practice. The training faculty are experienced teachers and family therapists who work in public and private settings and have demonstrated a specific commitment to disadvantaged and multiple-need families. Every effort is made to match agency needs with the specialities of particular trainers.

The Center offers training programs in family-based program development, family-centered case management, intensive family services, supervision of family-centered services, training of trainers, family development specialist certification, supervision of family development, family-

based services for substance abusing families, family reunification, post-adoption family therapy, and multicultural awareness.

National Staff Development and Training Association (NSDTA)

NSDTA is an an affiliate of the American Public Welfare Association (APWA) that includes as its members individuals who are responsible for staff development and training activities in the human services at public welfare agencies at the county and state levels, at voluntary/nonprofit agencies, and at organizations that provide contract services for training and consultation in human service agencies. NSDTA has a strong interest in working toward reinstituting a more supportive federal policy toward vital training efforts. Activities of NSDTA include a newsletter disseminating information on staff development and training issues, an annual conference, and special projects. As one of these special projects, NSDTA recently completed a national survey of state public welfare and human service agencies regarding their training policies, programs, and practices.

New York Parents Initiative

This initiative, which was first proposed by Governor Cuomo in his 1991 State of the State message, seeks to increase the availability of parent education and support services, improve the quality and coordination of services at both the state and local levels, and promote public awareness and understanding of the importance of parent education and support.

The guiding principles of the New York Parents Initiative emphasize family-identified strengths and skills, offering a family-centered approach to services that respects the diversity of families, developing programs which employ staff from the local community that are culturally and linguistically sensitive to, and representative of the populations served, offering a flexible array of service components in supportive community services, and providing coordinated and effective linkages to other services that family needs. As one of the initial steps, five Adult Centers for Comprehensive Education and Support Services (ACCESS) were selected to develop and implement the Initiative. These centers, sponsored by the state Education Department, offer an array of employment and self-sufficiency services and make parent education and support services available.

An important component of the New York Parent program is staff training and support for parent educators. The program has developed a *Staff Training Resource Guide* with information that will help staff of the centers that are in need of training. The guide includes information on resources available both within and outside state government.

Philadelphia Child Guidance Center Family Therapy Training Center

The Philadelphia Child Guidance Center (PCGC), has been conducting inservice, family-centered training to public agencies for over 20 years (for example, they provided training to the Philadelphia and Delaware reforms described later). In 1991, Baltimore Substance Abuse Systems, Inc., awarded PCGC a two-year family therapy training grant under the federal Target Cities Program, to provide family therapy training and support services to the staff in most of the public and some private substance abuse treatment programs in the city of Baltimore. The structural family therapy systems model upon which the training is based was developed originally for use with inner-city, low-socioeconomic populations and then generalized to other populations. The training dramatically changes substance abuse treatment practices which, currently, seldom

include family members. (Also see description of PCGC's statewide, home-based training program on page 42.)

The Target Cities Program (TCP), administered by the Office for Treatment Improvement, U.S. Department of Health and Human Services, funds cooperative agreements with eight major American cities to improve city-wide drug treatment systems by developing partnerships to ensure comprehensive and coordinated delivery of services. State drug abuse agencies are eligible to apply for the three-year target cities demonstration projects.

The consultation and training contract established has three major segments: (a) needs assessment; (b) staff orientation; and (c) intensive training of the clinical staff.

The needs assessment is based on the assumption that the training providers and staff from the substance abuse treatment centers should co-design the competency-based curricula, the training process, and the short- and long-term evaluation criteria for the training project. After the needs assessment has been completed, orientation conferences are held with directors, administrators, supervisors, and clinical staff to provide an overview of the training and support services to be provided under the initiative.

The training directors of programs are asked to select one or two clinical staff members to receive the training from the PCGC's consultants. Each trainee receives approximately 33 days of training over the two years of the project. Staff members receiving this training, with the support of the consultants, train other staff members in the techniques learned.

Training is both didactic and experiential, using both live interviews and consultation, videotape, reviews, and role plays. In addition, there will be videotapes, videocameras and monitors, and other supplies available for use by participants of the project.

The second phase of the project will involve the training of supervisors and more intensive training of trainers in every region to ensure that family-centered training becomes an integral part of the services.

United Neighborhood Houses (UNH)

UNH is engaging in a public/private partnership with New York City officials to pilot and test a new model for providing integrated, neighborhood-based, comprehensive services for children and families and to eventually replicate the settlement house model across the city. UNH serves as a catalyst and key broker in helping to plan and implement this initiative and has worked in collaboration with officials at state and federal levels on components of this initiative. In addition, the reform is involving the settlement houses in a series of activities designed to increase their capacity to deliver more coordinated and effective services to their neighborhood residents.

It has been the experience of UNH that settlement houses have staff with widely divergent professional training and norms. This diversity frequently creates considerable institutional resistance to service integration and coordination and that training is required to help overcome the resistances. However, most of the training provided by public agencies to settlement workers tends to emphasize paperwork and reporting requirements.

With funding from the DeWitt Wallace-Readers' Digest Foundation, UNH is launching a comprehensive, multilayered human resource development program to address issues of staff recruitment, retention, and development. This project will involve all 39 settlement houses in New York City. This includes in-house as well as external opportunities for: (a) training staff of settlement houses on methods to foster service integration; (b) staff training to assure relatively

standardized responses of high quality from all staff, in all the houses; (c) staff development opportunities to help managers and supervisors provide staff with new or updated learning required to function in their changing job environment; (d) special trainings, as needed, to tackle emerging problems or training needs; and (e) a scholarship aid to assist staff in educational development via partial scholarships to post-secondary schools.

University of North Carolina at Chapel Hill, School of Social Work

In North Carolina, a model for child mental health case management training is being implemented through a contract between the state's Department of Human Resources and the School of Social Work at the University of North Carolina. The model establishes a collaborative process for content development involving the state Division of Mental Health Children and Youth Program, three child mental health demonstration programs, a child mental health advocacy organization, and the School of Social Work.

This case management training was developed around a specific *value base*, *knowledge* relevant to the population to be served and the service system, and *skills* needed to provide the service, including relating to children in the mental health system, engaging in partnerships with their parent or responsible adult, and facilitating interprofessional collaboration. The training takes into account the trend in service delivery systems toward thinking in terms of wrap-around services geared to the particular needs of the child and the family, rather than in terms of categorical services delineated by agency function.

Uplift Incorporated, North Carolina

Uplift 's goals are to both develop local capacity and leadership around systemic change and to provide assistance to empower change at the local level. In order to meet its goals, Uplift provides extensive training and technical assistance to elected officials, community leaders, and business representatives. This includes:

Technical assistance. Field operation staff provide intensive, on-site technical assistance in selected counties to teams of elected officials, business, and community leaders, health and human service providers, and families who seek to implement strategies to support families.

Resource Center for Local Communities. This Center offers statewide leadership development training, strategic planning assistance, and access to research and institutional resources to implement strategies of support for families.

Training and curriculum development. Uplift works to develop and refine training for frontline workers and community leaders to help them learn how to empower families in their communities. Uplift is sponsoring a Family Development Specialist certification project which led to the development of a statewide coalition of family workers.

County collaboration replication project. Uplift is initiating a county collaboration process (based on the Council of Governors' Policy Advisors Academy Process). Through this process, they will offer policy development and implementation assistance to twelve counties that want to implement comprehensive plans for improving outcomes for families and children. The policies that result from these collaborations should help counties learn how to: (1) integrate programs across departmental lines; (2) build partnerships with the private for-profit and not-for-profit sectors; and (3) more effectively target strategic initiatives to improve the well-being of families.

Zero to Three/National Center for Clinical Infant Programs

The NCCIP sponsored a national program to improve the training of practitioners (from different disciplines) providing services to infants with special health care needs and their families. The **Training Approaches for Skills and Knowledge (TASK)** project, funded by the Smith Richardson Foundation, provides a framework for thinking about key training issues that are meaningful to the multidisciplinary group of individuals involved in working with infants, toddlers, and their families, and to develop a common language for dialogue.

The TASK project developed a series of publications under the title, *Preparing Practitioners to Work with Infant Toddlers, and Their Families,* to assist all the major groups working with families with young children (professionals or different disciplines, parents, policymakers, educators and trainers). These publications identify four elements of training that are particularly helpful when training family practitioners. These include: (a) a knowledge base built on a framework of concepts to all disciplines concerned; (b) opportunities for direct observation and interaction with a variety of children under three and their families; (c) individualized supervision that allows trainees to reflect upon all aspects of their work; and (d) collegial support, both within and across disciplines that begins early in training and continues throughout the practitioner's professional life. The publications also discuss the evaluation of competence in individual practitioners and in service programs; describes promising training approaches that are currently underway; and summarizes in non-technical language seven core concepts common to all disciplines concerned with infants, toddlers, and their families.

QUESTIONS AND ISSUES ABOUT INSERVICE TRAINING

(Sources: Gallagher, *et al.,* 1989; Gilkerson and Young-Holt, 1993; National Commission on Children, 1993)

In general, policymakers allocate very limited resources to training and have given little thought to the various issues involved in providing effective inservice training, and few seem to appreciate how important a component it is of effective service delivery. A selection of the issues and questions relevant for policy are as follows.

Systems change linked to effective training

Most training initiatives promoting new models of service delivery eventually realize that several aspects of the agency's administrative, financing, personnel, and compensation systems may need to be changed to support the goals of the training. If these changes are not made, the trainees will be continually frustrated and unable to put into practice what they learn. For example, if the training requires direct contact with family members or other professionals, these contacts must be counted on time sheets as direct service hours and included in employee's job evaluations. Such changes in practice, and the philosophy underlying them, need to be identified and negotiated. Ideally, this will be done in the early stages of designing the training program with administrators, supervisors, union representatives, and frontline staff.

Is inservice education effective?

More and better research on the process of inservice education is desperately needed. Unlike preservice education in which there usually are standards for the evaluation of competencies acquired (as demonstrated in exams, term papers, etc.), the field of inservice training is rather

chaotic with few criteria for the evaluation of inservice efforts. Even though there seems to be a consensus on the components of effective inservice education, most inservice training is only evaluated in terms of trainee satisfaction and not in actual changes in participant behaviors and ultimately in benefits for families being served by trainees. There also needs to be an examination of the relative costs and benefits of conducting training in-house or with outsiders under contract.

Cost effectiveness of inservice training

Programs providing services to multiproblem families usually have high rate of staff turnover. There is growing evidence from some of the reform initiatives that when staff are provided with strong and sound ongoing training and supervision, the staff remain in their jobs longer. For example, the Pennsylvania Family-Based Mental Health Services Training demonstrated that during the first year of their program, staff included in the training and supervision initiative had a significantly lower rate of turnover than case management staff that were not receiving the training (see p. 42).

Unfortunately, when administrators are faced with competing demands on scarce resources or the need for budget cuts, funds allocated for staff training and support are usually the first to be cut. In the long run, this is counterproductive and results in an increased level of staff dissatisfaction, higher rates of turnover, and, therefore, less effective and more costly services for families.

Skills for trainers and supervisors

It has been generally assumed that the skills needed to deliver services can be readily adapted to the skills needed to teach or to supervise others to deliver the services. For example, in many human service agencies, supervisors tend to be promoted rather than prepared for their role as supervisors. It is important that supervisors be trained in skills in clinical supervision as well as administrative management.

Few integrated programs (with multidisciplinary teams) are able to meet fully the training and supervision needs of their staff. Therefore, they bring in consultants with expertise in specific content areas, pay for courses at nearby colleges, or send staff to participate in specialized workshops. To follow up on these trainings, it is critical to invest resources in training on-site staff that can provide ongoing supports and supervision. Without the investment in training on-site trainers or obtaining regular supervision from local consultants, the effect of inservice training programs is quickly dissipated.

Union attitudes and support

Some reform initiatives have found that union resistance can be a serious barrier to reform when reforms are interpreted as a threat to job security or requiring workers to do more complex jobs without being given fair compensation. In situations in which labor unions are strong, agency administrators must be careful to involve them early on in the planning of any inservice training initiative and be as open and explicit about any implied changes in job responsibilities in order to assure their cooperation and defuse possible resistance from the staff.

In addition, unions are concerned about assuring that staff are given fair access to any training which may result in enhancing their opportunities for promotion or job change. They will also want to assure that employees are fully apprised of the purpose and focus of the training. Optimally, employers should involve representatives of the unions in planning the content of any

inservice training. At the least, they should be given the opportunity to review and comment on them.

PART III. NEW CAREERS/PARAPROFESSIONALS

(Sources: Pearl, 1981; Pearl and Reissman, 1964, 1984; Pickett, 1984)

Creating new types of jobs and careers is the third human resource development strategy currently being used to achieve the goals of family-centered, integrated services reform. These new careers are created, in part, to bring into the human services workforce people whose own racial, cultural, and economic background mirrors those of the clients being served. This current development echoes the experience of the New Careers movement of the sixties and seventies, which grew out of a similar dissatisfaction with the ineffectiveness of services.

History of the New Careers movement

Based on the experience of three demonstration programs, Frank Reissman and Arthur Pearl wrote two very influential books promoting a new type of training, "New Careers," for people whom they called "paraprofessionals" (Reissman and Pearl, 1965).

"Hiring the poor to serve the poor, we argue, is a fundamental approach to poverty in an automated age. (Human service jobs are the least likely to be automated out of existence.) At the same time that it provides vastly improved service for those in need, this approach can also reduce the manpower crisis in the health, education, and welfare fields where there is great and growing need for personnel despite widespread unemployment in the society as a whole" (Pearl and Reissman, 1965, p. i).

This idea was picked up in several pieces of federal legislation which funded ambitious New Careers programs out of various federal agencies and offices, including the new Office for Economic Opportunity, the National Institute for Mental Health, and the Departments of Labor, Education, and Justice (probation and parole).

The New Careers concept involved recruiting community or "indigenous" people, usually with little formal education, and providing them with intensive on-the-job training in a human service field. In some areas, these paraprofessionals had experience as former clients of the system they were entering as staff (e.g., ex-mental patients, felons, addicts, etc.). This on-the-job training was generally supplemented with course work provided by a cooperating local university or community college. The trainee would gradually, over the course of several years, proceed up a carefully structured career ladder from an "aide" to an associate and eventually to a fully qualified professional.

Two somewhat independent rationales were used to promote the New Careers idea and both influenced the development and implementation of these programs. The first, promulgated by Reissman and Pearl, was the conviction that trained paraprofessional staff would be more effective at providing services than more traditionally educated staff. They would also help to change the practices of the bureaucracy which were so ineffective in serving low-income individuals and minorities.

The second main rationale was that New Careers offered low-income residents a route out of poverty. These anti-poverty goals essentially captured the support of policymakers and influenced the direction and design of the programs. This had the unfortunate, but predictable result that the

New Careers movement became highly vulnerable to a change in Presidential priorities. Thus, when the Nixon Administration pulled the rug out from the anti-poverty programs, the movement lost most of its momentum, even though several evaluations had demonstrated their effectiveness (Pearl, personal communication). The New Careers strategy was in fact predicated on conditions of full employment. Paraprofessionals are entirely dependent upon employment by public systems and institutions. Thus, attacks upon these systems, and concomitant budget cuts, resulted in cuts in paraprofessional jobs in the seventies (Pearl, 1981).

In the sixties there was a large growth in the number of people serving in newly created positions as teacher aides, homemaker aides, lawyers' assistants, and community mental health assistants. Many lessons were learned from the New Careers programs about how to recruit and train paraprofessionals, overcome the resistance of existing staff and professional associations, and work with universities on modifying curriculum. The movement also underscored the importance of creating a step by step career ladder that would result in transportable credentials.

Many of the key concepts from the New Careers movement have been incorporated into the rapidly growing field of human services education. Currently, there are over 650 programs based in state and community colleges offering BA, Associate, and certificate programs in human services. The average age of trainees is 40 and many are unemployed white collar workers entering the field of adult human services for the first time. They get jobs in group and residential homes, elder care and disability services, substance abuse, and, most recently, in various shelter programs. A few of these training programs are beginning to become more family-focused due to the demand for training workers for employment in teen pregnancy programs and battered women's shelters. The Council for Standards in Human Service Education reviews and approves these training programs and issues a national directory.

We note below a few current examples of new careers established to achieve the goals of family-centered, integrated services reform.

Current Examples

Child Development Associate (CDA)

The Child Development Associate is a new career established in the field of early childhood development in the sixties to build a foundation of developmentally relevant principles, knowledge, and skills for staff working in Head Start programs. Unlike most other New Careers programs, it has survived and become firmly institutionalized at the national level and it remains the baseline credential for persons in early childhood care and education.

The CDA credential is earned through a competency-based accreditation system (usually a master-apprentice relationship without formal academic prerequisites) administered under a contractual agreement between the U.S. Department of Health and Human Services and the Council for Early Childhood Professional Recognition, a nonprofit corporation also known as the CDA National Program. CDA credentials are granted to early childhood educators and caregivers in family day care, center-based, and home visitor programs that serve families with children up to five years old. In each of these categories there is a Bilingual Specialization category.

The CDA curriculum includes the following 13 functional areas: safety, health, learning environment, physical development, cognitive development, communication, creative development, self development, social development, guidance, family involvement, program management, and professionalism. These competency areas are strongly related to the quality standards set by the Federal Head Start Performance Standards.

The standards of competency are the same for all candidates, but the methods of training to achieve competency differ among programs. There are two options:

- CDA Professional Preparation Program Option. This option vests an academic institution with primary responsibility for planning and delivering formal instruction/CDA training leading to the final assessment of the candidate.

- CDA Direct Assessment Option. The grantee/Head Start program is primarily responsible for planning and delivering acceptable, formal instruction/CDA training leading to the final assessment of the candidate.

According to the Head Start Act, as amended on November 3, 1990, Head Start programs must ensure that, by no later than September 30, 1994, each Head Start classroom in a center-based program is assigned one teacher who has a CDA credential (or a certificate or degree which meets or exceeds the requirements for CDA).

CDA training funds are available through CDA Scholarship Act funds as well as through other sources such as the Job Training Partnership Act (JTPA) funds, Title IV-A Child Care Licensing, Monitoring and Improvement Grants, Social Services Block Grant, Dependent Care and Development Block Grant, Head Start, USDA Child Care and Family Food Program, and Training Personnel for the Education of the Handicapped.

Family Development Specialists (FDS)

Family development is a model of family-based intervention designed to help all families, but especially low-income families, improve family functioning and achieve economic independence. The program was initially designed by the National Resource Center on Family Based Services (NRCFBS), as a "family-based equivalent" to Head Start's Child Development Associate (CDA) training, to help trainees acquire skills to work with families. Some of the skills emphasized during the training are: helping families to review their needs, stresses, and strengths, imagine another reality and set goals to realize it, enhance family relationships, develop competencies they need for economic independence, use developmental resources in their community effectively, and meet other families for support and collective action.

The eight-day training program is usually spaced out over several sessions to facilitate the absorption of material and to give trainees the opportunity to practice what they have learned. Participants (both paraprofessionals and professionals) have structured homework assignments and take a written test on course materials.

Although the training was initially used with staff working in child welfare, NRCFBS trainers are now providing the training to early childhood programs (Head Start and Comprehensive Child Development Programs), income support, employment and training (JTPA, JOBS), mental health, community action, and county extension programs serving low-income families. Since 1988, over 500 Family Development Specialists in several states have been certified nationwide. There are plans to incorporate Family Development Specialist Training in the new Children's Initiative funded by the Pew Memorial Trust.

Training is also available for supervisors. The two-day Family Development Supervisor Training is designed to help supervisors effectively guide and support family development workers and enhance their own growth as professionals. In addition to the basic course leading to a certificate, NRCFBS provides "refresher courses" to renew and refresh supervisors and staff who have been

working with families for six months to a year. These trainings usually last for two days and the areas of emphasis are selected by the agency staff.

Resource Mother's Program, South Carolina

Over the past decade a number of adolescent pregnancy and parenting programs have paired older mothers from the community with the teenage mothers to provide them with support, advice, and to serve as positive role models. One such program with a strong training component is the Resource Mothers program, which began operating in 1981 in three counties in South Carolina and has become an established component of South Carolina's Division of Maternal Health. This project serves teenagers who are pregnant with their first child. The teens are counseled by *resource mothers* who are experienced mothers, high school graduates, and residents of the area. Women are selected for their personal warmth, successful parenting experience, knowledge of community resources, demonstrated ability to accept responsibility, and evidence of natural leadership. Resource mothers are expected to assume the roles of teacher, role model, reinforcer, facilitator, and friend.

An intensive six-week training program was designed for the first group of resource mothers. The curriculum included material on pregnancy, labor and delivery, family planning, nutrition, communication skills, infant stimulation, home visiting techniques, well-child development, community resources, referral skills, and work with extended family. Training emphasized inherent strengths, within both the adolescent and her environment, that could be used to enhance decisionmaking and the development of life skills.

Currently, the same training is done at the state level in two-day sessions, twice each year, to develop skills and allow time for the resource mothers to share expertise. Other training opportunities are made available through the Division of Maternal Health and inservice programs of other agencies. When a new resource mother is hired, the district coordinator is responsible for her general orientation and instruction in specific content areas. The statewide training sessions offer an opportunity for a new resource mother to form relationships with her colleagues from other counties.

A Master's level social worker, using a social support model of supervision, assumes responsibility for the weekly supervision of each resource mother. The supervisor helps the resource mother understand the principles underlying her work with adolescent mothers, their families, and the health care system. This program is supported by a grant to the Medical University of South Carolina from the Robert Wood Johnson Foundation.

Youth Development Associate (YDA)
(Costello and Ogletree, 1993; Pittman and Fleming, 1992)

Several youth-serving organizations, universities (i.e., University of Northern Iowa and Chapin Hall at the University of Chicago), operating foundations (i.e., the Carnegie Council on Adolescent Development and the Center for Youth Development and Research), and the National Assembly of Voluntary Health and Social Welfare Organizations have been meeting to identify the competencies and core knowledge required to work effectively with youth and their families. Part of the focus of these discussions has been on issues of accreditation, standards, and professionalization, as well as problems of compensation, recruitment, and retention of staff working in youth-serving organizations.

As a result of these discussions, and as part of the creation of a Consortium for the Education and Training of Children's Services Workers, the Chapin Hall Center for Children at the University of

Chicago is proposing to explore the possibility of designing a Youth Development Associate process that would be the baseline criterion of competence for primary services work with school age children and youth. The consortium would explore the cost-effectiveness of creating this credential or of expanding the current CDA credential (described above) to school age children and to youth and families from middle school to 21 years of age.

Other Emerging New Careers. New types of jobs and careers are evolving in many other program fields to meet newly emerging needs and new service models. For example:

New roles for parents. In the field of early intervention, and to some extent in children's mental health, parents are receiving training to perform a variety of new paid and unpaid roles. Parents of children with special health care needs can now be trained to serve as parent advocates, policy advisors, and case coordinators or case managers for their own or others' children.

New roles for foster parents. In child welfare, foster parents for some years have been receiving specialized training in order to provide therapeutic foster care to seriously emotionally disturbed or delinquent children. More recently, a demonstration training program in New York City has trained foster parents to work cooperatively and directly with the biological family in order to promote the child's return home (see Minuchin, *et al.*, 1990). This concept is being incorporated into a wider reform initiative called, *Family to Family: Reconstructing Foster Care*, funded by the Annie E. Casey Foundation.

PART IV. TECHNICAL ASSISTANCE

(Sources: Bruner, 1993; Elder, 1992; Gardner, 1992; Wynne, *et al.*, 1986)

Technical assistance is a process by which a client seeks help and advice from a more experienced professional or organization to deal with a specific issue or problem(s). When technical assistance is requested by a reform initiative, it generally concerns needing help with some aspect of the planning or implementation processes. (Other disciplines, like business management and some mental health groups, use the term "consulting" to describe the process of technical assistance.) Generally, technical assistance is requested when the expertise is not available in-house and the type of help needed is believed to be of limited duration. Thus, a time-limited or task-specific contract can be negotiated rather than seeking to add a new staff position.

The underlying assumptions of technical assistance are: that key organizational factors and individual practices, behaviors, knowledge, and skills that characterize effective and successful practice can be identified; that people who are involved in these programs can modify their practices and behaviors; and that these practices and behaviors can be taught. The mechanism for "teaching" these practices and behaviors is the focal point of the technical assistance.

Technical assistance is a type of knowledge transfer. Often, the consultant providing technical assistance is sharing the lessons learned from other similar reform initiatives. Technical assistance differs from direct training in various ways, although sometimes part of the technical assistance process is to provide some limited training or design a training program. Because technical assistance is usually requested voluntarily, the agency or program is free to implement or reject the recommendations received.

The content of technical assistance in family-centered, integrated services reform initiatives usually includes help with: (i) strategic planning and creating an environment to support systems

change; (ii) strategies to achieve collaboration through new forms of governance; (iii) specific nuts and bolts of system change---financing, personnel, contracts, etc.; and (iv) family-centered, frontline practice.

Since many different types of specialized knowledge are often needed in these ambitious, collaborative, and cross-system reforms, a technical assistance agreement may specify that the individual or organization serve as a broker to help access other specialized consultants.

In discussing school-community initiatives, Sidney Gardner (1992) argues that consultants are most effective in the following roles:

- Questioning the basic policy assumptions of the process or pushing and helping the local team to make those policy assumptions clear when they have not been stated.
- Networking with project planners in other communities and states to give local planners a comparative sense of how another site handled the same issue.
- Providing actual expertise with particular school-linked service efforts in which the consultant may have personal skills and knowledge.
- Assisting with the conceptual or management processes needed to design and carry out a services integration initiative.

Common Strategies for Providing Technical Assistance

1. Implementation guides and model program descriptions

Numerous implementation guides which address many of the factors that are known to contribute to the production of better results/outcomes in service integration programs are either already published or under development. A partial list of publications to assist local communities in developing collaborative efforts around the needs of children and families is located in the references section of this report (see p. 53). Some of these guides have been very widely disseminated. There is no systematic information available about who uses these guides, what they are used for, or how useful they are found to be.

In addition, there are several descriptions of best practices or model programs that describe effective methods of providing comprehensive, integrated services for families with children and for young adults. Some guides also discuss barriers to providing the integration of services and the means of facilitating the efforts.

2. Strategic Planning

Strategic policy development and planning processes are essential first steps in any new reform initiative. These processes help policymakers crystalize their vision for the reform, help the key stakeholders buy into this vision, and develop a set of concrete, measurable objectives and steps needed to achieve the goals. Most of the more ambitious reforms to date have used one or another type of strategic planning process, often with the help of outside technical assistance. Some of the processes that have been used are briefly described here.

The Family Academy Process

The Council of Governors' Policy Advisors (CGPA) is a nonprofit, Washington-based organization which provides various kinds of technical assistance for its members, the nation's governors' policy and planning staff. An Academy is the Council's most intensive form of technical assistance. Since 1989, the CGPA has held two Policy Academies on Families and Children, for a total of 17 states which were chosen through an RFP process. Each Academy was an intensive, two-year process that included three weekend-long, structured work sessions for teams of up to 10 high-level policy officials, appointed by the Governors, from each state. These meetings led the state teams through a strategic policy development framework and provided them with structured opportunities to learn about and discuss the problems and trends affecting family well-being. The teams have also held various follow-up meetings back home to continue work on the process between Academy meetings.

The final goal of the Academy was for each state to develop a set of outcome-oriented policies and cross-agency reforms to guide public and private planning, funding, and service delivery efforts over a span of years.

The Academy affords participants an opportunity to work together with top officials from their own state, while sharing information and gaining perspective from similar teams representing each of the other states, and from a group of national experts.

In addition to the 17 states which have participated thus far in the Family Academies, several reform initiatives have received technical assistance from CGPA consultants in order to implement the "family academy" process in local community planning efforts (for example, North Carolina and Colorado).

Future Search Conferences
(Source: Weisbord, 1992)

To be successful, systemic changes in organizations require that people understand deeply how the whole system functions and that staff (inter- and intra-agency) define a shared vision of what a better system would look like in order to craft the statement of goals that incorporates the most important concerns and problems of all the players.

The *future search conference* is a strategic planning tool which has evolved from the field of organizational development. It involves getting whole systems in one room for one to three days, and uses structured activities to focus on the future and then develop strategies for reaching the desired future. Search conferences seek to excite, engage, produce new insights, and build a sense of common values and purpose. They are particularly useful for organizations faced with significant change. One technique used within search conferences is the *environmental scan*, which describes the network of outside pressures on an organization. Future search conferences have been widely used throughout the world in the corporate sector, but increasingly are being used to help communities and nonprofit organizations solve problems and plan new directions.

River of Culture
(Source: Cordova, Morris, and Probasco, 1992)

It is useful to think about an organization as having a distinct culture which evolves over time. Every organization has a culture shaped by the experiences, values, and vision of its collective membership. The culture is impacted by factors such as past and present members, community values, and the organization's policies and leadership. The Idaho Department of Health and

Welfare and Oregon's Children Services Division applied family-based principles, including ideas about family assessment and storytelling, to the idea that an organization has a culture. It then developed an organizational assessment and intervention tool known as The River of Culture.

The process begins by bringing members together and arranging them in order of organizational longevity. Beginning with the elders, the members tell the agency story by talking about issues such as: what the organization was like in the old days, what the priorities were, who the leader was and what his or her own agenda was, who the heroes were, etc. This discussion continues until everyone tells his or her story, which is added to the River. Participants are then asked to identify themes that they have noticed during the process, and these themes are listed on flip charts or illustrated on the River. This process starts the identification of some of the issues the organization needs to address, both positive and negative. It is especially critical for organizations contemplating change initiatives.

Family Impact Analysis
(Source: Ooms and Preister, 1988)

Although these strategic processes have been successful in clarifying the broad vision and goals for reform initiatives, the process of translating these goals into the specific changes needed in ongoing policies and programs has been largely idiosyncratic and somewhat haphazard. The Family Impact Seminar has developed and tested over the years a framework and systematic method for analyzing the effects of specific programs and policies on diverse families and different aspects of family life. The framework helps to organize the vast, complex, and fragmented body of information and research related to families and program implementation, and to pinpoint specific areas needing change. The Family Impact Analysis framework and tools can be used by reform initiatives in their strategic planning, needs assessments, and policy and program evaluations.

The guide, *A Strategy for Strengthening Families: Using Family Criteria in Policymaking and Program Evaluation,* identifies a list of criteria that can be used to assess the effects of proposed and existing policies and programs on family life and well-being. It also proposes six broad family principles to guide public policy and specifies a list of family impact questions to be incorporated as family criteria in program evaluation and policy analysis.

3. Resource Centers, Technical Assistance Consortiums, and Clearinghouses
(Source: NCSI, 1993)

Over the last decade in the social policy field there has been an amazing growth of private sector organizations serving as resource centers, clearinghouses, or as members of technical assistance networks. As the problems of children and families became more acute and services were realized to be so ineffective, the demand for information to understand the problems better and learn what approaches seem to work has escalated. This trend is clearly a market response to the realization that great quantities of information in the human services area are being produced, but the information is highly fragmented, chaotically organized, and, hence, largely inaccessible. These new organizations are generally nonprofit organizations funded by public or private foundations.

Resource Centers. There are numerous federally and privately funded resource centers that bring together practitioners, administrators, and experts to disseminate information, develop written resource materials for communities and practitioners, and sponsor a variety of workshops and conferences. Most of these resource centers provide technical assistance by matching their capabilities to the needs of the agencies and communities requesting the assistance.

Clearinghouses serve to provide information and advice upon request through the mail or by phone.

Technical assistance networks or consortiums are usually groups of individual experts who have agreed to provide technical assistance upon request, either as individuals or teams, and who generally share information about their experiences with other members of the network so they can be continually updated on the progress in the field.

The following organizations are serving in one or more of these capacities and are frequently being called upon for assistance by state- and community-based, family-centered, integrated service reform initiatives.

Chapin Hall Center for Children at the University of Chicago

The Chicago Community Trust (CCT) launched an ambitious Children Youth and Families Initiative that funds community-based, integrated systems of social services for children, youth and families in Chicago. The goal of the Initiative is to demonstrate how services can be reconceived and reorganized to strengthen communities' commitments to their children and families. The Trust has made planning or project grants available to eight demonstration communities in the metropolitan Chicago area.

In 1990, the Trust asked Chapin Hall Center for Children at the University of Chicago to conduct an assessment of the education and training issues that should be addressed in conjunction with the initiative. The assessments and discussions that followed led to a proposal to establish an *Education and Training Consortium* which would define and disseminate common primary services principles, knowledge, and practices to paid staff, volunteers, supervisors, and managers, and become the foundation for a more effective and integrated system of primary and specialized services. This proposal is still being evaluated.

Family Preservation Technical Assistance Forum

As part of its commitments to establish and expand Intensive Family Preservation Services (IFPS) the Edna McConnell Clark Foundation funded the Center for the Study of Social Policy (CSSP) to develop a Family Preservation Technical Assistance Forum. The Forum is a group of experts from around the country that provide technical assistance to state and local initiatives on all aspects of IFPS development and implementation, including financing, performance tracking, development of cross-systems efforts, evaluation, targeting services, and others. The Forum has published the monograph, *Building Training Capacity for Developing Intensive Family Preservation Services.*

In addition, the Forum's written products, as well as other materials related to the development and implementation of IFPS, are available through the Family Preservation Clearinghouse, which is another project of the Center for the Study of Social Policy.

National Center for Service Integration (NCSI)

NCSI was established in 1991 with funding from the U.S. Department of Health and Human Services (DHHS) and private foundations. Its primary mission is to stimulate and actively support service integration efforts across the country by serving as a technical assistance resource and an information clearinghouse that maintains a computerized file of practitioners, policymakers, and consultants who have expertise in planning, implementation, and evaluation of collaborative

initiatives. NCSI is itself a collaboration of six organizations which each bring a particular set of resources and expertise to bear on the functions of the Center.

The six participating organizations are:

- Mathtech, Inc., the lead organization, Princeton, NJ, and Falls Church, VA
- The National Center for Children in Poverty, Columbia University
- The Child and Family Policy Center, Des Moines, IA
- The National Governors' Association, Washington, DC
- The Bush Center for Child Development and Public Policy, Yale University
- Policy Studies Associates, Washington, DC

National Early Childhood Technical Assistance System (NEC*TAS)

This system, established in 1987 under P.L. 99-457 and reauthorized in 1991 under P.L. 101-476, brings together individuals and organizations which represent diverse disciplines and parent perspectives to address the infant, toddler, and preschool provision of IDEA. NEC*TAS consists of six organizations with an advisory board and consultants which offer technical assistance and support services to states and other governing jurisdictions.

The goals of NEC*TAS are to assist states in the development and expansion of services for children, from birth through 8 years of age, at risk for disabilities and their families; to assist Early Education Program for Children with Disabilities (EEPCD) projects in developing and disseminating program models; to link state and EEPCD projects to facilitate the exchange of information about models of service delivery and practice; and to disseminate information about policies and practices nationally. The six participating organizations are:

- Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill (Coordinating Office)
- Department of Special Education, University of Hawaii at Manoa
- Federation for Children with Special Needs
- Georgetown University Child Development Center
- National Association of State Directors of Special Education (NASDE)
- National Center for Clinical Infant Programs (NCCIP)

NEC*TAS will be holding a special conference in Savannah, GA, on *Evaluation of Outcomes of Training and Technical Assistance Efforts* on October 19-21, 1993.

National Resource Center on Family Based Services (NRCFBS)

Funded by the U.S. Department of Health and Human Services, the NRCFBS provides technical assistance, staff training, research, and information on family-based programs for public and private human services agencies at the state, county, and community levels. With the goal of developing innovative high quality family-centered services programs, the Center provides technical assistance through telephone and on-site consultations as well as reviews of agency policies and procedures. The primary objective of the Center's work is the development of innovative, high quality, family support, family development, and family preservation services across the country.

Telephone consultation helps the caller to fully express and evaluate agency needs and the Center's information specialist then gathers relevant materials to meet those needs from the Center's collection of over 5500 documents related to family-based programs and practice. Callers may also be referred to other agencies who have struggled with similar issues or who have developed exemplary programs.

On-site consultation, largely offered through funding from DHHS, assists agencies with organizational assessment, organization and staff development, program design, implementation and maintenance, and program evaluation. This assistance is provided by Center staff along with a team of experts who have led program development in their own localities. To date, the Center has provided direct technical assistance in more than 25 states and has been instrumental in major initiatives to create family-centered service systems in three states: Idaho, Missouri, and North Dakota.

The Research and Training Center on Family Support and Children's Mental Health Interprofessional Education Project at Portland State University

The goal of this project is to prepare professionals to function effectively in interprofessional and interagency settings at all levels. This program develops and disseminates interdisciplinary training materials to prepare professionals to provide family-centered, community-based materials and to promote collaboration among agencies and professionals on behalf of families with children who have serious emotional disorders.

Zero to Three, The National Center for Clinical Infant Programs (NCCIP)

NCCIP is a multidisciplinary organization that offers a variety of opportunities for professional development to individual practitioners, agencies, and communities. NCCIP focuses attention on issues affecting all children and families in the first three years of life. The following are some of NCCIP's principal avenues for training and technical assistance.

Zero to Three. The bulletin of the Center is published five times a year. It provides reports of innovative research and service programs, essays on conceptual, clinical, and public policy issues' case reports, and information on new publications, conferences and training opportunities, government initiatives, and funding sources.

Training of Trainers Seminars. In order to provide a continuing resource for professional development, NCCIP began working with local planning groups to organize three or four-day, intensive courses which then serve as catalysts for establishing ongoing study groups. Intensive courses were held in New York and Chicago. Training of Trainers Intensive Summer Seminars have been held to help teams of educators and trainers expand their knowledge, enrich their teaching approaches, and achieve specific improvements in infant/family training in their home communities.

NCCIP Fellowship program provides enrichment for advanced trainees who are sponsored by directors of selected training programs in several areas or by community-based clinical or public policy agencies. Fellows attend a special one-week seminar and NCCIP Scientific Meetings and training institutes.

4. Exemplary Centers

Identifying and using exemplary service settings as learning laboratories is another means to shape attitudes and to teach skills and behaviors necessary to deliver high quality services. Douglas W. Nelson of the Anne E. Casey Foundation suggests the need for identifying and funding a network of exemplary service centers which should serve as learning centers for the training or retraining of professionals (Nelson, 1991).

One example of such a network already exists. As part of its efforts to develop new approaches for the training of Head Start staff, the Administration for Children, Youth and Families funds 14 demonstration *Head Start Teaching Centers*. These centers must provide quality services in all components of Head Start and must also be able to provide quality training to visiting Head Start staff. The training provided at these centers is participatory and relies heavily on observation, guided practice, and immediate feedback.

Head Start Teaching Centers may provide intensive training over a relatively short time frame, e.g., one to two weeks, or may provide training periodically over a longer time frame, e.g., six months to one year. Trainees include staff from nearby Head Start programs as well as staff from the Head Start Teaching Center.

ISSUES IN TECHNICAL ASSISTANCE

Lack of follow-up to technical assistance efforts

A particular area of concern with technical assistance efforts is the lack of follow-up to many of the providers. Many human services agencies indicate that technical assistance providers usually come in, make recommendations, and then leave the agencies believing they have "fixed" the problem or with the responsibility of implementing suggestions that, in many cases, are not relevant. In order for a technical assistance provider to be successful, it is critical that part of the technical assistance effort specify the mechanisms that will be used to follow up with the recommendations or, in the case of training efforts, to document how the training provided will be followed up in an ongoing fashion by trained supervisors and/or linking the agency to local, community-based, family-oriented trainers or case consultants.

Fragmentation of training and technical assistance efforts

The fragmentation of information and the limited communication among agencies and organizations providing training and technical assistance to various reform initiatives makes it impossible to quantify the precise number of training, educational, and technical assistance activities, or of individuals providing these activities. Some of the efforts overlap and duplicate each other. At the same time, there are many gaps in the types of assistance available. This all means that it is difficult for those who need training and assistance to know whom to turn to, for what kinds of assistance.

Some way to improve the organization of this knowledge-broker network needs to be found in order to facilitate a more rational and efficient use of available resources. This may be difficult to achieve, in part because many of these organizations compete with each other for funding and for clients. The scope of an improved services reform resource network would need to be considerably broader than any of the networks listed above. Several models exist that perhaps could be adapted, such as the NEC*TAS consortium or some system of regional resource centers similar to the Head Start centers.

In addition to identifying the core knowledge and skills required for staff providing services in the reformed systems, this organized network could systematize information about educational programs and training resources, facilitate access to resources (workshops, programs, trainers, consultants, and materials), highlight the inadequacies in the quantity and quality of training resources, and coordinate future training plans for preservice and inservice training.

PART V. STATE TRAINING INITIATIVES

State governments, which traditionally have been more directly responsible than the federal government for human service training, are beginning to launch some ambitious, family-centered training efforts that cross systems and government departments and are often jointly funded. In some cases these initiatives have emerged in response to new federal mandates. In other cases they are seen as the key tool to implement a more promising service strategy. In most cases they draw upon some sources of federal training monies and are supplemented with state dollars. The nine examples briefly described in this section are clustered into three broad program fields: (i) early childhood prevention and early intervention; (ii) family preservation; and (iii) family self-sufficiency.

Building on these current initiatives, states now need to develop permanent, in-state capacity for training, often at universities, and a stable financial base to support training as an integral part of program development and a key component of quality assurance (Center for the Study of Social Policy, January, 1993).

EARLY CHILDHOOD PREVENTION/EARLY INTERVENTION

California: Early Intervention Technical Assistance Network (CEITAN)

CEITAN provides training and technical assistance to aid in the development of a family-focused and integrated early intervention system in California. This project provides support to the lead agency for Part H (the Department of Developmental Services), the six participating state agencies, the Interagency Coordinating Council, and twenty-six local interagency coordination areas. The network is funded by the Department of Developmental Services on an interagency agreement with the California State University (Sacramento). Among the several tasks of the network is the responsibility to provide training and technical assistance for program implementation of Part H throughout California. In addition, CEITAN serves as a statewide technical assistance center and as a clearinghouse for requests for information and support on early intervention.

A variety of curricula have been developed for training, funded by federally funded personnel preparation grants, state-level training projects, and university-level training programs. In addition, the Personnel Advisory Committee has developed a recommended system of personnel development and standards which will be used to guide training efforts statewide. The Network includes four interdisciplinary graduate training projects in California.

In addition, CEITAN includes families as an essential component of all their training and technical assistance efforts. This Family Network is used extensively to provide trainers for parent-professional collaboration modeling. They have conducted statewide training and facilitation to develop family representation at all levels of policy development, and at the local interagency coordination level.

CEITAN is developing a clinical teaching model to be incorporated in the training and technical assistance system. They are planning to co-sponsor a regional leadership institute for family-professional mentors to promote family-focused service delivery and family-professional collaboration in IFPS development.

The state-level financial commitment for CEITAN is shrinking. The proposed budget amount for training and technical assistance in early intervention is less than half of what it was over the past few years, even though the amount of federal funds coming to California is more than doubling. In addition, from 1987-1992, the Special Education Division funded training and technical

assistance at approximately $800,000 per year (through Personnel Development for Infant Preschool Programs). This program was discontinued. The Federal Child Care Block grant funds had also been earmarked for training for child care and development staff in the area of children with disabilities and this has also been eliminated.

Contact: Linda Brecken, (916) 641-2927.

Hawaii: Healthy Start

Healthy Start is a home visiting program for the prevention of child abuse that originated in Hawaii. It focuses on child health and development of infant and toddlers at risk by targeting their families, mostly their mothers. In addition, it coordinates a range of services to the most needy families in the community. The program begins by screening families at the time of birth for factors associated with child abuse or neglect, such as poverty, single parent status, substance abuse, inadequate housing, and inability to cope with parenting problems. Once a family is identified as needing support, paraprofessional staff may begin visiting regularly in the home. These visits are more frequent and for a longer period of time than in most other programs. The impetus for the establishment of Healthy Start came initially from the private sector, but it is now institutionalized within the public sector. This has led to the expansion of the Healthy Start program to the entire state.

The success of the Healthy Start model is due, in part, to the standardized training program which has allowed the first demonstration to share experience with the new teams being developed and establish uniform standards of service delivery as the program expanded. All training is coordinated through the Healthy Start Training and Technical Assistance team.

Training is provided in three phases. In Phase I all new teams participate in a five-week orientation, which includes a core curriculum developed collaboratively by educators, human service providers, medical professionals, home visitors, and social service administrators. During the orientation, the managers and supervisors, early identification workers, and home visitors receive training specific to their jobs. Trainees "shadow" experienced workers and visit community resources. The training for early identification workers typically takes place in phases. Phase I is three days of specialized instruction plus several weeks of closely supervised work. Phase II occurs four to six months later when all staff attend a five-day advanced training session. This training reinforces key concepts and introduces additional concepts that workers would have been unlikely to absorb during the initial orientation. After a team's first year of operation it begins to participate in Phase III, or inservice training. Each team receives four half-days of inservice training per year at its own site, choosing topics from a menu of offerings distributed annually. (This mechanism has been particularly useful for programs in remote areas of the state.) Phase IV training is the supervisory training which focuses on the supervisor/home visitor relationship in its broadest sense.

Training is provided by the Healthy Start Technical Assistance Team and by community consultants who have been identified as both experts in the field and very good presenters. Including consultants has increased awareness of Health Start among other community agencies and the universities, helping to enhance overall service coordination. The Technical Assistance Team also provides regular TA through visits to all Healthy Start sites, thus assuring standardized practice and clear communication among all teams statewide.

The Healthy Start Network, comprised of managers and supervisors from each team, meets each quarter for planning and program development.

Contact: Betsy Pratt, Hawaii Family Stress Center, (808) 922-5020.

Nebraska: Early Childhood Training Center

The Early Childhood Training Center in Nebraska is a statewide training project established to provide information services and on-site training and consultation to professionals in the field who serve young children (birth through age 8) and their families. The goal of the Center is to provide training and consultation to staff in the field of early childhood education; this includes those working with young children with disabilities as well as children being served in child care, Head Start, preschool, and home settings. Activities are planned to enhance training opportunities available across the state and to provide ongoing support to develop an interdisciplinary model of delivering training which will enable participants from a variety of disciplines and agencies, as well as a variety of community settings, to effectively implement training strategies to meet the needs of families and children. The Center is funded by the Department of Education, Offices of Child Development and Special Education.

On-site training has been provided to all level of staff, in a wide range of areas. Trainers are the current practitioners, doctors, teachers, psychologists, social workers, and other professionals who can bring skills and knowledge on site. In addition, through their *Family Systems Project,* the Center is training staff from various agencies across the state to become trainers of personnel working with families who have young children with special needs. This curriculum is based on a systemic approach to families which seeks to maximize the skills and abilities of all family members. Trainers continue to receive ongoing support to enable them to provide their communities with the capacity for continual training.

The Center also supports the design of family-centered information resources and parent education materials that will promote the capacity of Nebraska families to enhance their development and that of their children. The parent education project is a collaborative effort of several state agencies, with leadership from the Nebraska Departments of Social Services and Education.

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FAMILY PRESERVATION

Delaware Department of Services for Children, Youth, and Their Families, (DSCYF)

In 1982, the state of Delaware consolidated most children's services into the Department of Services for Children, Youth, and Their Families (DSCYF). DSCYF includes protective services, child mental health, and juvenile corrections (youth rehabilitative services). Alcohol and other drug abuse treatment services for adolescents are a part of this same service system, with programs for adolescents in the juvenile system falling under youth rehabilitation services.

One of the basic assumptions of DSCYF is that the success of this initiative depends on the understanding, motivation, and skills of the staff in the public and private sectors who carry it out. It is the belief of the DSCYF administration that line staff determine state policy, in that they make critical decisions that require them to both interpret existing policy and improvise in the many areas where policy is silent. Therefore, after very careful planning and a competitive bid process, the Department initially contracted the Philadelphia Child Guidance Center to provide a comprehensive program of training in the family-based approach to services. In subsequent years, a team of private consultants continued the program.

The training project's goal is to present basic family systems concepts and practice techniques for working with families to be applied by staff within their jobs. For example, they teach juvenile justice staff how to provide family-focused juvenile justice services, child protective staff how to provide family-focused protective services, and mental health staff how to provide family-focused mental health services.

In order to create a "departmental culture" based on family-focused understanding and values, every employee, from the top administrators to the telephone operators, received at least some level of training in family-focused practice. Initially, the training was divided into five levels of intensity which were structured to provide an increasing amount of detail on both philosophy and practice. Selected frontline workers and their supervisors were given advanced clinical training.

Contact: John VanDeusen, (302) 234-2127.

Idaho: Division of Family and Children's Services

In 1989, Idaho consolidated its child welfare, juvenile justice, and adoption programs into the Division of Family and Children's Services (DFCS). In addition to this reorganization, DFCS involved its field staff (nearly four hundred people) in an agency-wide adaptation to principles of family-centered practice which had been used in some divisions since 1984. To provide the training required to implement this ambitious reform, extensive, multi-level training has been and continues to be provided by DCFS. The family-centered practice model has recently been extended to include child care, child mental health, JOBS, and substance abuse treatment.

This ambitious and multicomponent training includes: (a) a two-week orientation to all management in the family-centered model (b) a two-week academy for all supervisory staff was provided by the National Resource Center on Family Based Services (NRCFBS); (c) a fifty-hour course in family systems training for all direct service and supervisory staff; and (d) a four-week, ongoing Idaho Academy program for all newly hired direct service staff. These staff include members of the community, juvenile probation officers, schools, and others. The curriculum developed by the Idaho Academy, with the help of the NRCFBS, is competency-based and consists of classes and supervised field practice. Students obtain a certificate at the end of the Academy. New workers are not permitted to do solo work before having this certificate.

Other types of supports and personnel preparation efforts include: (a) a commitment to hire/train clinical supervisors; (b) contracts for clinical consultation and other specialized training have been established in most regions of the state; and (c) an agreement with Boise State University by which DFCS pays half the salary, plus the tuition and books of six social work students who commit to work with DFCS for five years after obtaining their MSW. These students do their field work in DFCS agencies.

To increase the likelihood that services are delivered in a standardized and equitable manner around the state, all state employees in DFCS and allied professionals working in DFCS have the opportunity to attend the Academy. This includes law enforcement officers, school teachers, and others. This training program is funded with several sources of federal monies (Titles XX, IV-A, and IV-B, and NCCAN grants) in addition to state dollars.

Contact: Ken Patterson (208) 334-5700.

Illinois, Families First

The Family Preservation Act became law in Illinois on January 1, 1988. In 1989, under the Family First initiative, the Illinois Department of Children and Family Services (DCFS) funded private sector projects to offer family preservation services in the state. In the Spring of 1990, the Family First initiative expanded the partnership to extend the program throughout the state and added family reunification projects.

The DCFS created the Child Welfare Training Institute to provide training to DCFS staff. Private agency Family First staff may attend the training workshops offered by the Institute.

Training is required and provided to all new staff, and on an ongoing, voluntary basis for all personnel. To ensure a standard, quality response, separate curricula have been developed in three substantive areas---family preservation, family reunification, and substance abuse. In addition, the same trainings are offered across the state: two-day training for newly hired family reunification workers; three-day family systems training for families and for family reunification workers; an optional five-day workshop on substance abuse training with a follow-up component; and an optional juvenile court skill training. In addition, a category of Family First first-line supervisory training began on January of 1993.

The training is funded with federal (IV-A) and state dollars.

Contact: Mary Duda (217) 985-8745.

Michigan: Families First

Michigan was one of the first states to develop an extensive, in-state training capacity for family preservation services. Six full-time trainers from private agencies are under contract to deliver Families First, Michigan's intensive family preservation program. In addition, six IFPS specialists, who are part of the civil service system and have completed the Behavioral Sciences Institute's Trainer of Trainers program, train Department of Social Services (DSS) referral workers. The Families First trainers deliver the six-day core training once a month or as needed. They use the Behavioral Sciences Institute curriculum, but have added certain modifications. Ongoing training on special topics and skill enhancement is provided regularly on a regional basis.

In addition, Families First has developed training for referral and collateral workers, and implements this training on a quarterly basis. Training is provided in each of the state's six regions, and professionals from a wide range of health and social services are invited to attend.

Although staffing a full-time training and consultant division has been much more expensive than the costs of contracting these services out. Michigan has been able to hide their costs in their contract agency budget. Part of the funding for this training initiative comes from Title IV-A.

Contact: Susan Kelly, Coordinator, Families First, Michigan, (517) 373-3465.

Pennsylvania: Family-Based Mental Health Services Statewide Training

In 1988, the Pennsylvania Bureau of Children and Youth Services, Office of Mental Health funded the Family-Based Mental Health Services training program through the state Child and Adolescent Service Systems Program (CASSP). In addition to program costs, dollars are allocated through this initiative for staff training and program evaluation, both of which have been conducted through

a subcontract with the Philadelphia Child Guidance Center. The training program is in the middle of its second three-year cycle of funding.

The intervention model selected uses a multisystemic approach to provide mental health and family support services in the homes of families having seriously symptomatic children and adolescents at risk of out-of-home placements. The families are referred to community-based agencies for family-based mental health services from mental health, child welfare, drug and alcohol, juvenile justice, and education agencies. The theoretical approach underlying this initiative includes a family systems focus, integration of child service systems (mental health, child welfare, drug and alcohol, juvenile justice, and education), parental empowerment, and parent advocacy. Treatment is systemically oriented in that both the family system and the local child service systems are the foci of change efforts.

The competency-based training curriculum was developed by a team composed of parent advocates and child service system providers including mental health professionals working in home-based, outpatient, and inpatient programs. The curriculum emphasizes: (1) applied clinical skills knowledge (i.e., the trainees bring videotaped, in-home interviews depicting where the therapist is "stuck" in assessment skills and/or creating change; training input is geared to giving the trainee understanding of assessment, how to create change sequences, etc.); and (2) applied didactic knowledge (i.e., trainees are exposed to learning modules that range from areas such as family and risk assessment, intervention, and treatment planning to the application of these skills in areas such as physical and sexual abuse, substance abuse, adolescent suicide, crisis intervention, cultural diversity, or how to work with various family forms).

The training targets every level of agency staff, from the top administrators to the home-based programs' staff. Training begins with initial technical assistance/training days provided to regional, county, and agency program directors and county CASSP representatives. Subsequent training (17 days per year for three years) is then provided to home-based staff.

An important component of the training is the use of videotaped clinical interviews with the client families in their homes. The tapes are shown in the bimonthly training sessions which are conducted in four state regions. Staff in a total of 41 agencies are receiving training which continues for a period of three years, at which time the trainees are given a certificate qualifying them as Systemic Home-Based Therapists.

While the initiative started as a "pilot," the training ensured good clinical work and, as a result, the evaluation demonstrated successful treatment outcomes for the children and their families. Therefore, the state legislature voted to permanently fund new service and training programs in the 45 Mental Health-Mental Retardation programs serving the 67 counties in Pennsylvania. Programs are now able to receive reimbursement through the Medicaid program and private insurers. The unit of service is the child **and** the family. All activities related to helping the family are billable (i.e., meeting with other agencies) even if the family is not present.

The training initiative has been financed with state Mental Health and Department of Public Welfare dollars and collaborative contributions from other state offices, namely the Department of Education, local home-based programs in each county, and administrative costs under Medicaid. (Training costs are an administrative allowance reimbursed at 50 percent and billed quarterly by the state.)

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FAMILY SELF-SUFFICIENCY

Implementation of the 1988 federal Family Support Act would appear to require states to make vigorous efforts to train staff in how to undertake assessment of family and child care needs, as well as assess family factors that affect the employability of the welfare client. Several local JOBS-related demonstration programs have indeed focused on training staff to address the two-generational aspects of welfare reform (see Smith, Blank, and Collins, 1992). However, states have apparently restricted their inservice training activities almost exclusively to administrative issues arising from the regulations and there has only been one state, Iowa, that is known for implementing a strong family-focused training program as part of JOBS.

Iowa Family Development and Self-Sufficiency (FaDSS) Demonstration Program (Source: Bruner and Berryhill, 1992)

There are few state welfare programs that have a vision of family self-sufficiency which includes goals not directly tied to employment. FaDSS was designed to work with AFDC families and offer them a broad range of supports that go beyond employment and training. A key element of the FaDSS program is the family development specialist, who serves as a partner to families in their work toward self-sufficiency. Programs work to improve parenting skills, child school performance, self-esteem, housing, and other issues identified by participating families. As such, this program offers an opportunity to examine a welfare-related program that takes a family approach to welfare reform.

FaDSS Grant Program was created by state legislation in 1988, and ten separate demonstration sites were funded. Services are targeted only to those families which exhibit characteristics of long-term, welfare-dependent families. Early in its evolution, the FaDSS program was integrated with the JOBS program. This allows the state to receive federal financial participation for FaDSS program expenditures.

Training and supervision of family development specialists has been critical to this program. All ten FaDSS sites now use the Family Development Specialist Training developed by the National Resource Center on Family Based Services. The design of the training was financed by the Iowa Association of Community Action Agency Directors. All staff took the initial eight-day certification program. Some of the supervisors have taken the supervisory training.

Each of the sites includes training in their budgets and pays the NRCFBS for the training provided.

In addition to the initial training of family development specialists, all the sites have worked toward developing a team approach for supporting family development specialists with frequent staffings of FaDSS workers. For sites where a number of family development specialists work in the same office, weekly staff meetings are common.

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PART VI THE FEDERAL ROLE

Our partial review of new initiatives in training and technical assistance has revealed an impressive and rapidly growing amount of activity. The emerging family-centered service reform movement is creating a rising demand for new models of personnel training and for a wide range of types of

technical assistance. Many states and local authorities are mobilizing the resources needed, even in tough economic circumstances, to plan and fund these efforts.

Although states have drawn upon federal monies to fund most of these training initiatives, federal leadership has been largely absent, and some, though not all, sources of federal training dollars are rapidly declining. Moreover, the new models of training and technical expertise have largely been developed in the private sector, by a variety of consultants and nonprofit organizations, with the help of private foundation funding. If the reform movement continues to gain momentum, and state and local governments persist in pushing for major changes in service delivery, the demand for training and technical assistance will quickly outstrip the supply. If the need for training is not able to be met, the reforms are unlikely to succeed.

It becomes urgent then to ask questions about the role of the federal government in training and technical assistance. What is its responsibility and capacity to help nurture the infrastructure of reform? Before identifying a few possible options, we will briefly review some examples of how the federal government has exercised creative leadership in the past in promoting and supporting new approaches to training and technical assistance in order to achieve improvements in the services the federal government funds.

Examples of the federal role in training

• **Head Start and Early Childhood.** The Head Start program has always included a strong focus on providing resources for frontline staff and administrator training and technical assistance. The authorizing legislation specifically addresses these needs and over the past decade they have been provided through four major vehicles: a regionally based delivery network of resource centers; direct, supplementary funding to grantees for training and technical assistance purposes; funding national, one- or two-day training institutes in key and emerging substantive areas; and development of training materials and manuals related to the major components of the Head Start program. With the emerging interest in expanding and improving the quality of the Head Start program, there is renewed interest in assessing and improving the effectiveness of these activities.

The federal government also played a critical leadership role in the original planning for, and funding of, the Child Development Associate credential and training program (see p. 27).

• **Maternal and Child Health-SPRANS.** The Maternal and Child Health Bureau has funded many innovative, family-centered and interdisciplinary training activities through the grants program known as SPRANS, the Special Projects of Regional and National Significance. Grants have been used to support the training of new cadres of health care professionals (e.g., specialists in adolescent medicine and adolescent health care) and family-centered approaches to service delivery. They have funded interdisciplinary training required to provide comprehensive maternal and child health care, provided professional consultation and technical assistance, and upgraded the skills and competencies of state and local maternal and child health personnel, especially when confronted with new health issues such as the surge in the number of babies born to crack-addicted mothers.

• **Early Intervention/Special Education.** The federal government has a long track record of supporting interdisciplinary training through funding what are known as the University Affiliated programs, a national network of programs which provide interdisciplinary training for personnel serving adults and children with disabilities. Some of these programs are beginning to provide training to personnel in other service systems, such as Head Start programs, to increase their capacity to serve children with disabilities.

In the last decade, especially since the passage of P.L. 99-457 in 1986, the Office of Special Education and Rehabilitative Services in the U.S. Department of Education has helped prepare professionals and paraprofessionals from a variety of disciplines to implement the coordinated and family-centered services required by the law to be provided to families with infants of toddlers who have special health care needs. Grants to states and organizations have funded a wide variety of training and technical assistance activities and materials.

• **Child Welfare.** Federal child welfare dollars---in particular Title IV-E of the Social Security Act---have been a major source of funding for innovative training activities focusing on family preservation and reunification. Because states receive 75% federal reimbursement for eligible training expenditures under Title IV-E, strong incentives exist for a state to qualify its training activities to receive these funds. However, the absence of federal regulations specific to Title IV-E training has led to inconsistent and limited federal guidance to states on how they may spend these monies. Some states have recently claimed a considerable amount of federal training dollars, others have claimed much less than allowed.

The Children's Bureau has given strong support over the years to a network of resource centers. One of which, the National Resource Center on Family Based Services, has been very actively providing training in family-focused child welfare services in many states and counties.

• **Mental Health and Substance Abuse/SAMHSA.** Federal mental health and substance abuse programs have traditionally provided substantial support for clinical professional and paraprofessional training in these fields. These monies have been sharply cut back, and the agencies were reorganized in 1992 under a new umbrella agency, the Substance Abuse and Mental Health Services Administration. As a result, there is ongoing reassessment of the focus and direction of training and some new directions and initiatives are emerging.

For example, **the Center for Mental Health Services** clinical training grants program, which recently had its funding reduced from $10.8 million to $2.9 million, has had a strong focus on multidisciplinary training and a heavy emphasis on supporting minority trainees. In addition, grants have been awarded to training projects focusing on five underserved populations (chronic mentally ill, seriously emotionally disturbed children, elderly, minorities, and rural areas). Since 1981, a condition of receiving a training stipend or fellowship was that the trainee undertook to pay back one month of service by working in an approved setting with a priority population for each month of federal financial support as a clinical trainee.

In February 1993, the Center sponsored a multidisciplinary conference on developing a competent work force. The conference report, soon to be published, is expected to recommend that the training program focus on developing demonstration training projects that emphasize multidisciplinary approaches, cultural sensitivity, and collaboration with service providers, and that involve consumers and their families in the training.

The Center for Substance Abuse Prevention currently administers $14.5 million in training grants through its National Training System. It provides training and training of trainers for members of 19 health profession organizations and state trainers, including family medicine practitioners. Cross-system and interdisciplinary training are major themes, as are efforts to involve communities in community empowerment and change activities.

The Center for Substance Abuse Treatment has inherited the National Training System for Substance Abuse Counselors, formerly administered by NIDA. Some congressional concern

about the shortage of trained counselors led to a congressionally mandated manpower in substance abuse needs analysis study. The study is currently underway and will report in September 1993.

Options for a federal initiative on improving personnel training

The major challenge facing those committed to improving the effectiveness of service to children and families is to strengthen the capacity of state and local governments, in cooperation with the private sector, to accomplish the goals of current reform efforts. We have assembled below a number of suggestions for ways in which the federal government could demonstrate leadership through improving systems for providing training and technical assistance. These are put forward for debate and discussion in the hope that they will stimulate further ideas.

Since the reforms underway cut across many different service systems, departments, and agencies in the federal government, a key question is which office should assume the responsibility for coordinating an interagency effort on training.

(i) Conduct an inventory and assessment of federal health and human services training programs. Very little information is available about the scope of federal training and technical assistance activities which are scattered in dozens of offices throughout the federal agencies. A useful first step could be to compile an inventory of these programs to find out how these monies are spent, what the trends are, and to what extent they duplicate or complement each other. The next step would be to assess the potential of these training programs to serve as a catalyst for encouraging innovative, family-centered, collaborative training.

(ii) Help to sponsor and then disseminate the development of model family-centered training curricula for frontline workers to be adapted for different program settings and with different populations. At present, there are a number of scattered attempts in the private and public sector to develop more family-focused, collaborative training curricula. The federal government is in a unique position to bring some of these efforts together to share and cross-fertilize ideas, and then to help disseminate and promote them widely throughout the public service system. An integral part of the development of model, inservice training curricula should be the development of designs for evaluating their effectiveness.

(iii) Help establish a national, cross-system network of training and technical assistance resources in cooperation with private foundations and the nonprofit sector. As noted, existing sources of training and technical assistance in the private sector are scattered, fragmented, and, generally, not well connected with the resources that exist in the public sector. Private foundations that have played a leading role to date could join with the federal government in the development of a private/public resource network, perhaps regionally based, that would help to make training and technical assistance more accessible to the public service systems.

(iv) Offer demonstration and research funds to national professional associations to assess the adequacy of their professional training curricula for preparing professionals to provide family-centered, collaborative services. As noted, there are many reasons why professional accreditation bodies and state licensing authorities lag substantially behind the progressive leaders in their own disciplines and are very slow to incorporate new knowledge and practice skills into professional training curricula. The federal government could provide grants to encourage the national associations to work with some of the leaders in the reform movement in a reassessment of current training curricula.

(v) Offer financial incentives (or build in requirements in current grants) to universities and other training programs to conduct interdisciplinary and cross-

system preprofessional and inservice training. While providing federal demonstration grants for interprofessional training is a familiar method of promoting innovation, it seldom accomplishes system-wide change. Since most universities are highly dependent on federal grants of all kinds, it may be possible to find ways to build in financial incentives, or even requirements, for universities to conduct certain kinds of interdisciplinary training and research activities.

(vi) Fund research to determine which models and methods of family-centered, collaborative inservice training are most effective. In addition, it would be useful to have a critical review of the three decades of experience with training paraprofessionals.

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